DOCUMENT RESUME

ED 253 838 CG 018 041

AUTHOR	Wright, Janet M.
TITLE	Chemical Dependency and Violence: Working with Dually Affected Families. A Cross-Training Program Manual for Counselors and Advocates.
INSTITUTION	Wisconsin Clearinghouse, Madison.
SPONS AGENCY	Wisconsin Clearinghouse for Alcohol and Other Drug Information, Madison.
PUB DATE	82
NOTE	141p.
AVAILABLE FROM	Wisconsin Clearinghouse, 1954 East Washington Ave., Madison, WI 53704.
PUB TYPE	Guides - Non-Classroom Use (055)
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Advocacy; *Alcoholism; *Battered Women; Child Abuse; Counselors; *Counselor Training; *Drug Abuse; *Drug Addiction; Family Problems; *Family Violence; Incest; Legal Problems; Skill Development; Training Methods

ABSTRACT

This manual is designed as a cross-training program guide for counselors working in the fields of woman abuse and chemical dependency. (A cross-training program is a system for one (or more) agency personnel to train each other in their respective areas of expertise.) Chapter 1 discusses the rationale and goals of a cross-training program; issues in program implementation including participant resistance, and motivation; and the function of the group facilitator and the function and goals of the group. The remainder of the manual is divided into two sections, one on woman abuse and one on chemical dependency. Each section contains materials for approximately 18 hours of training divided into nine or ten sessions. The nine sessions on woman abuse include four sessions of basic information emphasizing the connection of woman abuse with alcohol and other chemical dependency (to be used sequentially), and sessions on men who batter, legal issues, children from violent homes, child abuse/incest, and wrap-up. The sessions on chemical dependency include introduction to chemical dependency and other drug abuse, assessment and intervention, the family illness and family violence, children from dependent families, women chemical abusers, fetal alcohol syndrome, a group approach to chemical dependency, and the wrap-up session from section one. The format for the sessions consists of statement of purpose, session outlines and objectives, instructions for the trainer, and references. The appendices provide evaluation forms, pre- and post-tests, a list of recommended films, and handouts. (MCF)

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CHEMICAL DEPENDENCY AND VIOLENCE: WORKING WITH DUALLY AFFECTED FAMILIES

A Cross-Training Program Manual for Counselors and Advocates

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A Cross-Training Program Manual for Counselors and Advocates

BY
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Published by:
WISCONSIN CLEARINGHOUSE
1954 East Washington Ave.
Madison, WI 53704

CG 018041

This Manual was produced as part of The Alcohol and Other Drug Related Family Violence Project, funded by the Wisconsin Bureau of Alcohol and Other Drug Abuse, Department of Health and Social Services, 1981. **©1982 Wisconsin Clearinghouse, Board of Regents of the University of Wisconsin System.**

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Acknowledgements

A manual such as this is based on information garnered from thousands of individuals and agencies and so the author can not really claim it as his or her own. I have attempted to give credit whenever possible to the source of my information.

In addition, several people in several agencies have helped to make this manual a reality and I would like to especially thank them. Most important was the input from Judy Popham of Madison General Hospital's Alcohol Program and Education Center who conceived of the necessity for this project, wrote the grant and helped write and rewrite the sections in this manual on chemical dependency. Without her dedication and determination this manual would never have become a reality.

The Wisconsin Bureau of Alcohol and Other Drug Abuse provided the grant which funded this project and provided much needed technical assistance.

The agencies which originally participated in and contributed to this training program were Stoughton Community Hospital Alcohol Rehabilitation and Education Center, Dane County Mental Health Alcohol Treatment Unit, Prevention and Intervention Center for Alcohol and Other Drug Abuse, Madison General Hospital Alcohol Program and Education Center, and Dane County Advocates for Battered Women. I thank them for serving as guinea pigs in the original training program and for reviewing and offering suggestions on the manual.

Steve Wilson, Family Services and Elthea Steidemann and Sharon Hanson, Parental Stress Center Staff also participated as trainers for this program. I would also like to thank staff at the Wisconsin Clearinghouse — Richard Yoast and Lynn Tolcott provided invaluable technical and editorial assistance and Jane Tenenbaum for design and production of this manual.

Finally, I would like to thank my friends, Leslie Morrow, Mary Lauby, and Geri Girard from Dane County Advocates for Battered Women and Cheri Maples from the Wisconsin Coalition Against Women Abuse for their assistance, feedback, criticism and support.

Janet M. Wright
1981

Explanations of Terms

Woman Abuse

While some information is provided on other forms of family violence, the focus of this manual is on woman abuse. The terms "family violence," "domestic abuse," and "spouse abuse" often serve to obscure the fact that most severe violence within families is directed at women and children. For a further discussion of this issue, see Dobash, R. Emerson, "The Negotiation of Daily Life and the 'Provocation' of Violence: A Patriarchal Concept in Support of the Wife Beater," paper presented at the 9th World Congress of Sociology, August, 1978, Uppsala, Sweden.

Advocate

The term "advocate" is used in the manual to refer to a person who works with battered women. An advocate is someone who supports, defends, or espouses a cause. This term has been adopted by many in the battered women's movement as a statement that battered women, in general, are not mentally or emotionally ill and therefore do not need counselors or therapists.

Chemical Dependency

While the emphasis in this manual is on defining chemical dependency as a disease, not everyone agrees with this model. Claude M. Steiner in his book, *Healing Alcoholism*, states that there is no proof that chemical dependency is an illness and feels that this disease concept can be misleading and even harmful at times.

Chemical Dependency/Alcohol and Other Drug Abuse

These terms are used interchangeably in this manual. Since the majority of violent families who have chemical problems use alcohol as their major drug, much of the material in this manual is aimed at examining the problem of alcohol abuse as opposed to other drugs.

Additional information on other drugs would necessitate another manual on the subject.

Family

The term "family" is used loosely here not only to include what we typically consider a family, that is a father and mother who are married and their children; "Family" here means any group of people living together as a unit and contributing to each other's lives. It could be a woman and her children, lesbian or gay men and their children, unmarried men and women who live together in a spouse-like relationship, or any other combination of people who form a household together.

Chapter I
Introduction

What is a Cross-Training Program?

This manual is designed to be used as a cross-training program for counselors working in the fields of woman abuse and chemical dependency. A cross-training program is a system for two (or more) agency staff to train each other reciprocally in their respective areas of expertise. This manual is divided into two major sections: Woman Abuse and Chemical Dependency. Chapter IV includes nine sessions on woman abuse to be used in training counselors in the chemical dependency field. The sessions are each 1½ to 2 hours long and can be presented on a weekly or bi-weekly basis. The second section includes ten sessions of 1½-2 hours in length for counselors or advocates in the woman abuse field on chemical dependency.

Because the subjects presented in this manual can be controversial and at times upsetting, the trainer(s) should have some skills in group dynamics and facilitation. While you do not have to be an expert, it would be preferred that you have taken a course for trainers or have had some training experience. It is ideal to have two facilitators for each training session so that one person can observe and guide the group process while the other presents the content. Trainers for the sessions on woman abuse should be working with or have worked with battered women. Trainers for the sessions on chemical dependency should be working with or have worked with alcoholics and/or other drug abusers. This doesn't mean that you have to be an expert in order to facilitate this training, but you should have some experience in the field. Your most important job as facilitator lies in planning, not in knowing all the answers.

This manual is a guide for people interested in providing training around alcohol and other drug abuse and family violence. It is not a directive. You are encouraged to pick and choose among what is offered here, with a few cautions: 1) Read the whole training manual before cutting out pieces. You may not understand the implications of one session for another unless you read the whole manual. 2) Don't leave something out because you disagree with it. First check out your own thoughts. Why do you disagree? Are you afraid to include that part? These sessions will probably bring up a lot of feelings and not all of them will be pleasant. But counselors may need to hear these ideas. Even if you still disagree, bring it to the trainees for discussion. Remember: a trainer is always a learner, too. 3) Don't leave out the experiential part of the session in order to save time. For many people, experiential training is the easiest and most lasting way to learn.

This is a manual for training the helping professionals and paraprofessionals around the issues of alcohol and other drug related family violence. The information and research available in this area is still very limited. As you learn more, you may want to do training updates. The perspective of this manual is not to provide all of the facts and up-to-date statistics, but to begin exploring how we can better provide services to families with the dual problems of violence and alcohol and other drug abuse. Our basic belief is that families experiencing both problems need to receive treatment for both problems. One area cannot be avoided because we are uninformed or uncomfortable with it. The goal of this training program is to provide counselors and others who work with families with enough information and comfort that they can offer help, including referrals, in both problem areas. The ultimate goal of providing such training is to change the attitudes of the trainees, not just to change the services, and thereby improve our services to families.

Why a Cross-Training Program?

The fact that there is frequently a relationship between violence and alcohol abuse is well-documented. Alcohol and family violence are even more closely tied together than alcohol and other types of violence. Between 40 and 95% of woman abusers were using alcohol at the time the abuse occurred.[1]

- Gelles, in a study of 80 families, found 44 families where violence had occurred and drinking accompanied this violence in 21 cases (47%).[2]
- Straus, in a study of 2,143 families, found that alcohol abuse was more clearly associated with violence in the spousal relationship than in the parent-child relationship.[3]
- Maria Roy, who founded Abused Women's Aid in Crisis (AWAIC) in New York City, has reported that alcohol and other drug abuse by the man was an underlying factor in over 80% of the cases AWAIC dealt with in 1976.[4]
- A Minnesota study of nearly 100 abused women who called a hotline found that 87% of the abusing men were alcohol users.[5]
- A survey of battered women in Ann Arbor, Michigan showed that 60% of the abusing men also abuse alcohol and that more than 66% of the assaults involved the use of alcohol.[6]

While the overlap between the two abuses is well documented, the helping agencies available generally remain distinct in their concerns and approaches. Most shelters around the country are crisis-oriented, grass roots organizations which grew out of the women's movement in the early 70's. They were founded to respond to women who were in crisis, often in life-threatening home situations. The overriding concern for these women was and is safety for themselves and their children. These shelters have often been more flexible than traditional helping agencies in providing services for both women and children, recognizing that many women stay in abusive situations partly out of fear that they cannot escape without losing their children. The women in these shelters generally have as priorities securing the most basic human needs: physical safety, shelter, food and clothing. In light of these overwhelming tasks, pursuing other concerns such as parenting skills and understanding family alcohol and other drug abuse problems has seemed like overloading the circuits. There are at least two well-known shelters in the country which do offer aid to battered women and their children when there is an alcohol problem as well, but few services aimed at battered women focus on alcohol involvement. Even in cases where the abuser is identified by the victim as alcoholic, the issue of treating the alcohol abuse is not always pursued.

On the other hand, alcohol treatment agencies and many other helping agencies fail to recognize, or in some cases ignore, signs that family violence is an accompanying problem. Clients are more likely to minimize than exaggerate the frequency and severity of physical abuse. Violence in a family may be only one of the many problems, but this "symptom" can kill.[8] Alcohol and other counselors not specifically trained to deal with family violence may not only be unaware of the resources, but also uncomfortable in bringing these problems out into the open. Child abuse, spouse abuse and alcohol/other drug abuse can and do occur in one family, although perhaps only one area is presented as a problem. The counselor must be able to assess objectively the situation.

This training program is based on three underlying assumptions:

1. That alcohol related family violence is a common occurrence.
2. That interventions must consider the family as a system.
3. That focusing on the family helps to: decrease defensiveness and blaming; reduce areas of conflict and promote ventilation of feeling; facilitate the learning of new behavior and the integration of adjustment; ameliorate the negative impact of abusive drinking/violence on other family members; reduce the families' isolation and educate family members as to the nature of alcohol and other drug abuse and family violence.

Women who are abused can and do seek help from a variety of sources — social service agencies, doctors, and friends. But all too often the situation is minimized or the treatment is inappropriate. Elaine Hilkerman (1978) reports that most of the battered women she treated had made frequent visits to emergency rooms and physicians with physical complaints, anxiety, insomnia or suicidal behavior. "Most had been treated usually inappropriately with sedatives and hypnotics, tranquilizers and anti-depressants," she said.[9] Often these women seek help for problems related to the violence and abuse, but service providers tend to deal only with the "presenting problem." They fail to look beneath the surface.

There are indications that getting service providers to perceive the need for the services depends more on the attitude of service personnel towards alcoholism and domestic violence than it does on any characteristic or need of the client population.[10] Pittman and Sterne found that negative professional attitudes were the major blockage to the treatment of alcohol abuse.[11] More recent surveys indicate that these negative attitudes are basically unchanged.[12] Moreover, efforts at education that do not take these attitudes and their underlying biases into account are likely to have little or no effect at changing actual practice.[13]

Rather than create new services designed specifically for families with both alcohol and other drug abuse and violence as problems, the idea of a cross-training program is pursued here for two main reasons. First, it is cost effective. There are presently services available for chemical abusers and there are services for battered women. Creating a new program would be bulky and costly. Secondly, many more families with the dual problems (chemical dependency and family violence) will be detected and aided if the respective counselors are well-trained and comfortable with both areas. A cross-training program is an effective and efficient method of reaching and more fully serving violent families with chemical dependency problems.

Who, What, When, Where, How?

Assuming that you have decided that the training program is a good idea for your community, how do you get it started? It's important to define who will be your first target for the training. Perhaps you feel your own agency needs training. Or your staff may be having particular problems with the staff of another agency. A cross-training project might be just what is needed to better understand each other's programs and problems. It is probably best to begin with one or two agencies, as the more agencies you have, the harder it becomes to cater to individual needs.

Once you have chosen a group or a group has requested your training and you have found out what their special interests are, you will need to plan how the sessions will be organized. One agency, for example, may have five one-hour blocks of time available for staff training. Another agency may want to do it in 2 full days. Because you are not setting up community workshops, but in-service training, you will have to be particularly sensitive to agency policies and protocol. The agency may not only have written rules around in-service training, but also an unwritten protocol of who should be consulted regarding the program planning. It might be important to have the directors or the staff supervisors of the different agencies meet together to discuss general planning. They might also help in the decision around who should facilitate each session. For example, you may decide to ask someone who is not within the agencies to do parts of the training.

You will also have to decide where to conduct the training session. Generally, it is easier for a staff to get to training if it is in their own building. However, there may be important reasons to look elsewhere. Ask yourself and some of the staff the following questions:

1. Is there a room large enough for the number of people to be trained?
2. Is it a comfortable atmosphere? Are the chairs comfortable? Is it pleasant?
3. Is it an atmosphere that is conducive to learning? Can you move the chairs for experiential exercises? Is there a chalk-board or flipchart? Are there spaces for small groups to meet in? Are there facilities for movie equipment?
4. Would the staff be more comfortable going elsewhere?

You will need to decide who will be the presenter for each section. Perhaps you will be presenting it all. Or perhaps there are experts in your community around specific subjects. For example, if you work in a shelter for battered women, you might ask a counselor from your local mental health center to do training on working with battering men, even though you are doing the rest of training on domestic violence. Or you might ask someone else to do the section on child abuse/neglect and incest. All of this will depend on what resources are available in your community. It is helpful to draw in other community experts so the trainees learn about other people in the community who are working with the problem of AODA related family violence.

Resistance

The most difficult job you will have as facilitator is overcoming any resistance there may be to the training program. One problem is that direct service workers are generally overworked and overextended. If they see the training program as possibly creating more work, they may understandably be reluctant to participate.

The primary problem with this subject matter, however, is likely to be fear and distaste. It is well documented that alcoholism and other drug abuse are subjects that create discomfort for many people.[14] Attitudes about drinking and drunkenness tend to be quite mixed in this country. On one hand, we are encouraged to drink heavily with such axioms as: "A man can really hold his liquor," or "Drinking is sophisticated," or "Drunkenness is funny!," etc. Alcohol has been revered as an anesthetic, relaxant and cure-all. Alcohol is used in rituals and religion as well as in leisure and social life. On the other hand, the United States has had a strong temperance movement since before Independence. Prohibition in the early twentieth century marked the height of this movement. The period since Prohibition has seen a backlash against this former rigidity. Prohibition is now generally seen as a highly offensive moralistic and unscientific attack on alcohol use.[15] And so our society has viewed alcohol with a good deal of ambivalence. Even today we have few traditions to govern our use of alcohol. The result of this societal ambivalence is that individuals are often uncomfortable with the subject of alcohol abuse. Because we have no clear definition of alcohol abuse, we can never be quite sure about our own usage of alcohol/other drugs, unless we totally abstain — and then we feel uncomfortable because abstinence is often seen as moralistic and judgemental. This makes it more difficult for us to confront others about their drinking, too, for the same reasons.

As if this doesn't make the training hard enough already, when you add on the subject of family violence you are really causing havoc in people's emotions. First, it challenges our cherished view of the family as a peaceful and supportive social unit. We want to believe that most families are like "The Waltons" on TV. Myths such as this are not likely to be tarnished without much pain and even anger.

Secondly, you cannot honestly confront the problem of family violence without also questioning the differing roles and status of men and women in this society. In fights between spouses, most of the time, it is the woman who gets severely injured.[16] It is important to approach family violence as a **family systems problem** and explore what that means. It is important to explore it as an **addiction**. And it is equally important to explore it as a **societal problem.** In a society where men obviously have the majority of the status and power while women and children are viewed as second class citizens, it is women and children who are far more likely to be battered. This confrontation with reality is likely to cause great discomfort and, in some cases, extreme resistance and anger on the part of both men and women.

A final cause for resistance may be a sense of distrust between two or more agencies or particular fields. For example, a staff that works primarily with alcohol and other drug abusers may distrust a shelter staff because they see them as breaking up families, taking sides with the women and ignoring the men (who may have a chemical dependency problem). The shelter staff, on the other hand, may distrust the chemical dependency staff for refusing to see violence as an equal problem to chemical dependency requiring immediate intervention, or for not recognizing the special problems of women in AODA related violent families. This potential antagonism between two social service fields can subvert the effectiveness of the training program if it is not addressed.

Motivation

Luckily, there are ways to minimize this resistance or even to turn it around into positive discussions. One of the jobs of the facilitator is to be a salesperson of the training program. Many of the techniques for motivating the participants will be discussed in the session-by-session content chapters. However, there are some general ideas to keep in mind:

1. Get to know some of the major issues for the people you will be training. What are their special problems and interests? How might your training make their jobs easier?
2. Spend some time confronting your own attitudes and feelings around the issues of alcohol and other drug abuse and family violence. What are your own fears and areas of discomfort? Take time to do some reading in those areas if you can. Then discuss these openly and honestly with the participants. Let them know that we all have limitations.
3. Share with the participants that this is a very difficult subject matter and that sometimes it will be hard for them to listen. Encourage them to talk about these feelings when they occur. Give them some historical background on why each of these subjects causes discomfort.
4. Try not to be defensive about your own views. Use your best listening skills when a participant is disagreeing with you. Remember that people learn at different rates and in different ways. Even if someone appears to be totally disgusted with the point you are trying to make, he/she may begin questioning his/her opinions later on. Keep a sense of humor.
5. Finally, learn a few ways to do conflict resolution. Defuse tense situations with humor. Ask the group to help if you get stuck. See if there

are parts of the issue that you can agree on. Let people know (and remember yourself) that it is okay to disagree — it doesn't invalidate the whole training program. And it can lead to some lively, healthy and growth producing discussions!

Experiential On-Site Training

Since one of the most lasting ways to learn is through experiences, it is important to include in the training program some visitation and actual experience with clients. Experience can be most enlightening in terms of changing attitudes.

The major roadblock that you will probably have to experiential training is lack of time. Therefore, don't leave it up to the individuals to simply sign up or it will probably never happen. Instead, it's a good idea to talk with the director or staff supervisors and set up a specific schedule for each staff person. For example, you might schedule each person on a shelter staff to do at least one assessment with an AODA counselor. Or you might schedule each person on AODA staff to spend 2-3 hours in the shelter. It is best to schedule this towards the end of the training sessions so the participants can apply some of their new knowledge.

Experiential training is the cement of the training program. It helps the participants understand how the pieces fit together. It also greatly increases understanding between two staffs regarding the intricacies of their different jobs.

Evaluations

Evaluations are an important learning tool for the trainer. There is no need to be intimidated if you look at evaluation as necessary feedback instead of as a grade card. Of course, every trainer can expect to get a few evaluations with very negative (and occasionally abusive) statements — especially when you are working with controversial subjects. But, most people will fill them out thoughtfully and you can use these to guide future training sessions. Always go through the evaluations and write down any ideas or issues that you think could be helpful to your planning. (See examples of evaluation forms in Appendix A.)

At a certain period, maybe three months after the training, you may want to ask the participants to fill out another evaluation form, letting you know how they have or haven't applied the training in their work. (See Appendix A.) This is especially useful if you intend to do some future in-service training as you will get an idea about what was lacking in the original training program.

Another way of evaluating your program is to ask the participants to fill out a simple test before the first training session begins. At the end of the training sessions, have them fill out the same tests and check to see if they have made changes. These tests can also be helpful learning experiences for the participants if you discuss the questions at some point. (See Appendix B for examples of pre- and post-tests.) A good evaluation system can vastly improve your training program.

A Word About Facilitation

As facilitator you will juggle several different roles in order to create a successful program. You will need to be an **organizer**, bringing together the people and the information and helping to create the necessary atmosphere for learning. You will also be a **host** or **hostess**, developing a comfortable atmosphere for participants. You will be a **discussion leader**, a **listener**, and a **time keeper**.

As a facilitator, one of the most important ideas to keep in mind is that you are a worker for the participants, not vice versa. You are there to provide them with new skills and tools that will help them do their jobs more easily and effectively. In turn, they are the direct service workers. They work for the family members who come in asking for help. Their job is to help these family members reduce the stress and pain in their lives. You can think of it as an upside-down triangle. (See Chart A). By keeping this in mind, you can avoid the problems of slipping into the belief that you know what everyone needs to learn. This is not to say that your own perspective is unimportant. It is simply to remind you that the participants won't learn unless they feel it is relevant to their own work and/or lives. This is why it is so important to constantly relate your training to the realities of the trainees. If you feel that teaching a specific subject, e.g., the problem of sex role stereotyping in our society, is important and the trainees do not want to hear about it, then you are going to have to discover some way of making it relevant to the trainees. If you don't, just going in and talking about it won't get you anywhere — no one will listen and everyone will end up frustrated.

Two booklets which would be especially useful in illuminating your roles as facilitator are:

- *A Manual for Group Facilitators,*[17] available from the Wisconsin Clearinghouse, 1954 E. Washington Ave., Madison, WI. 53704 (608-263-2797), $4.50 plus $1.00 (postage and handling).
- *Projecting: A Facilitator's Guide to Alcohol and Other Drug Film Utilization*, by Janice Kinsolving and Craig Wunderlich, 1979,[18] also available from the Wisconsin Clearinghouse, $2.50 plus $1.00 (postage and shipping).

Function and Goals of the Group

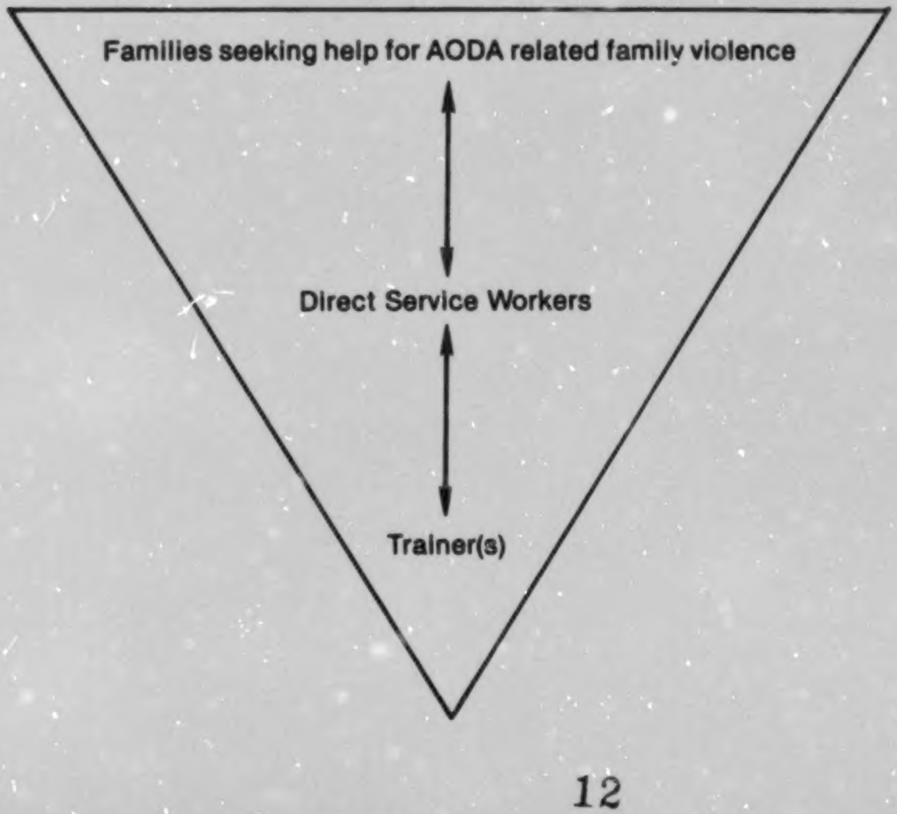
The function of your training group is *skill acquisition*. You are training people who are probably already working with AODA related violent families. They generally have training and skills necessary for basic counseling. This training is focused on teaching counselors specific ways of working with AODA related violent families. Of course, in order to impart knowledge and teach new skills, you are likely to have to also change attitudes. So this group will have both skill acquisition and values clarification as its tasks.

The goals of the training program are:

1. To raise awareness and understanding and to educate staff about AODA related family violence.
2. To increase staff skills around identification, intervention and treatment of AODA related violent families.
3. To improve the assessment and rehabilitation of families experiencing AOD related violence and to increase awareness of availability of services.

Each session will relate to one or more of these goals.

CHART A



Summary

1. *What is a cross-training program?*

A cross training program is a system for two or more agency staff to train each other reciprocally in their respective areas of expertise. This manual consists of two sections, one on woman abuse and one on chemical dependency. Each section contains materials for approximately 18 hours of training divided into 9 or 10 training sessions. These training sessions were developed to train counselors and advocates currently working in the fields of woman abuse and/or chemical dependency.

2. *Why a cross-training program?*

The overlap between the two family problems of violence and chemical dependency is well documented. However, the services available are generally quite distinct. Cross-training is recommended here as an attempt to close the gap between these services for families experiencing both problems. The goals of the training program are increased identification of and more effective services for families with both problems.

3. *Who, What, When, Where, How?*

1. First decide *who* you will target for the training program.
2. Find out *what* the people targeted see as their needs for training. Decide what you think can be included in the time allotted.
3. Decide *how* to organize the training. How many hours will it be?
4. Who will do which parts of the training? Involve the proper people from each agency in your planning.

4. *Areas of Possible Resistance*

1. The training may be seen as more work when the participants are already overextended.
2. The subjects of AODA and family violence are difficult ones that may stir up feelings of fear and distaste.
3. There may be distrust between workers in the AODA field and the family violence field.

5. *Motivation*

1. Get to know the major issues for the people you will be training.
2. Understand your own feelings and attitudes around the subject areas.
3. Let the participants know that it is difficult to talk about AODA and family violence because of our feelings.
4. Don't be defensive. Try to hear the grain of truth in what anyone is saying.
5. Get comfortable with a few simple methods of conflict resolution.

6. *Experiential On-Site Training*

Many people learn best through experiencing. This is also the best way to change attitudes. Make sure to schedule some on-site training for each participant.

7. *Evaluations*

Evaluations are an important way for you to get feedback on how your training is proceeding. Some of the evaluation methods would be verbal feedback, written evaluations after each session, written evaluations three months after the sessions end, and pre/post tests for participants.

8. *A Word About Facilitation*

As facilitator, you will need to play several roles: organizer, host or hostess, discussion leader, listener, and time keeper. A facilitator is a worker for the participants and must address their needs.

9. *Function and Goals of the Group*

This is a skill acquisition and values clarification training group with the following goals:

1. To raise awareness and understanding and to educate staff about alcohol and other drug related family violence.
2. To increase staff skills around identification, intervention and treatment of alcohol and other drug related violent families.
3. To improve the assessment and rehabilitation of families experiencing alcohol and other drug related violence and to increase awareness of availability of services.

Now you are ready to begin your training program. Don't forget to also relax and enjoy yourself. You are going to make mistakes — that's part of learning. But you will also have some good times — facilitating can be fun!

Footnotes and References

[1] Langley and Levy, *Wife Beating: The Silent Crisis,* (New York: E.P. Dutton), 1977. pp. 71-72.

[2] Ibid, p. 72.

[3] Straus, Murray A. "Cultural and Social Organizational Influences on Violence Between Family Members," *Configuration: Biological and Cultural Factors in Sexuality and Family Life.* Raymond Prince and Dorothy Barried (eds.) (New York: D.C. Heath, Lexington Books), 1974.

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[18] Kinsolving, Janice and Wunderlich, Craig. *Projecting: A Facilitator's Guide to Alcohol and Other Drug Film Utilization,* 1979. Available from Wisconsin Clearinghouse, 1954 East Washington Ave., Madison, Wi. 53704 (608-263-2797).

Chapter II

The Sessions on Woman Abuse

Getting Ready to Go

This section of the training is designed to train chemical dependency counselors to assess for violence in the families with which they work and then do some basic intervention as needed. This training program could also be used by counselors in other fields who want more information on woman abuse.

There are nine, one-and-a-half to two hour sessions in this training program. If an agency has limited time, the first four sessions contain the basic information on woman abuse and the connection to alcohol and other drug abuse. None of these sessions should be left out, as they build on one another progressively with pieces of necessary information. It is particularly important to include the two sessions on working with battered women (Sessions Two and Three) in the proper order.

Sessions Five through Eight have slightly different emphases.

Chapter Five is about working with men who batter; Chapter Six is on specific legal issues; and Chapters Seven and Eight are on children. Some of these topies may be of more importance to one agency than to others. The order of these sessions could be altered and some of them might even be eliminated or done at a later date if lack of time is a problem.

The final session, which is a wrap-up, is important for improving relationships between the two staff groups, understanding referral processes, and putting closure on the training program.

The nine sessions, then, that follow are:

1. **Introduction to Woman Abuse.**
2. **Working with Battered Women #1.**
3. **Working with Battered Women #2.**
4. **The Connections Between Chemical Dependency and Family Violence.**
5. **Working with Men who Batter.**
6. **Legal Issues of Working with Battered Women.**
7. **Working with Children from Violent Homes.**
8. **Child Abuse/Incest.**
9. **Wrap-up/Staff to Staff Workshop.**

Each session is arranged in the following format:

- First, the major purpose of the session is described. Then comes the agenda for that session on the same page. This page can be copied and distributed to participants at the beginning of each session.
- The next page outlines what each participant should learn by the end of the session and also contains particular instructions for that session for the trainer.
- The session is next outlined with the major points boxed for emphasis and including other supporting information.
- Each session description concludes with footnotes and references.

Now you are ready to begin the training sessions on woman abuse. Good luck and have fun!

Session I
Introduction to Woman Abuse

Purpose

To introduce the participants to some basic information on the reasons for and extent of family violence, as well as some limited historical background on the subject.

Agenda

I. Introduction
  A. Introducing yourself and participants
  B. Sharing an outline of the training program
  C. Questions, suggestions and expectations
  D. Discussion of basic rules
    1. Smoking
    2. Breaks
    3. Beginning and ending on time
  E. Discussion of evaluation process for program
II. Pre-Test and Questions
III. Break
IV. Film and Discussion
  A. Introduction
    1. Basic statistics and history of women abuse
    2. Things in film you disagree with or want people to pay particular attention to
  B. Film showing
  C. Discussion and questions
V. Evaluations

Objectives

At the end of this session, participants will be able to:

1. List at least two statistics regarding the extent of family violence.
2. Identify at least two indicators that woman abuse has been a problem historically.
3. Identify at least one relationship they have had that was abusive and that stayed in for what they believe now was too long.
4. List at least eight reasons why women might stay in an abusive relationship.
5. List at least five problems which contribute to men beating women.

Notes to the Instructor

Necessary Equipment:	Film Projector Screen
Optional:	Blackboard of flipchart
Handouts:	Handout #1 in Appendix D; copies for all participants
Homework:	Ask participants to keep mental track of (and/or clip out) articles, cartoons, comments, jokes, stories, information they see or hear on family violence until the next session. Ask participants to think about violence they have experienced in their own lives.

Evaluations

I. Introduction

A. Introduce yourself — who you are, why you are doing this course.
B. Share outline of training program.
C. Questions, suggestions, expectations
D. Discussion of basic rules
  1. Smoking
  2. Breaks
  3. Beginning and ending on time
E. Discussion of evaluation process

II. Pre-test and Questions

III. Break

IV. Film Introduction

1. Basic Statistics and History of Woman Abuse

Major Point #1: Family violence is not an isolated problem. It occurs at one time or another within half of all marriages. Family violence happens in all races, age groups and socioeconomic classes.

- The family is the focus of more violence than any other social unit.
- FBI estimates that every 18 seconds a married woman is severely beaten.

- Over half of all married women experience some form of violence during the marriage.[1]
- One child dies every 4 hours in the U.S. because of child abuse.[2]
- One out of four females are sexually abused before age 18. 75% of those are at home.[3]

You could also include some local statistics, as these often have a greater impact. If you cannot get local statistics from your community resources, you can extrapolate from national statistics. For example, if 1 out of every 2 married women experiences some violence during her marriage and there are 50,000 married women in your county, then 25,000 of them will probably experience some form of violence during their marriages.

Like alcoholism, family violence cuts across all class, racial and age lines.[4] Although women who stay at shelters are predominately (but not exclusively) from working and lower classes, this only indicates that they have fewer resources than the other classes. Statistics from hot lines/crisis lines generally show a much more equal distribution of women from all classes.

Major Point #2: Family violence is not a new phenomenon — it is rooted in centuries of traditions, laws and practices.

This is an important point to stress as some people erroneously believe that woman abuse, in particular, has increased as the women's rights movement has grown. We can't begin to understand the depth of this problem until we see the attitudes that have been passed down to us for hundreds of generations.

- The expression "rule of thumb" originates from an old English law which stated that a man could not beat his wife with a stick that was thicker around than his own thumb. The stick had to pass through his wedding ring in some municipalities.[5]
- In 1834, the Mississippi Supreme Court held that a husband should be permitted to "moderately chastise his wife," without problems from the courts.[6]

To begin exploring how deeply ingrained these attitudes are, ask how many of the participants have heard people make jokes about wife beating. People might recall how rape jokes used to be common and how they are generally considered unacceptable now. Woman and child abuse jokes are still considered funny.

Major Point #3: It is not easy for women to leave a violent home situation. There are many reasons why women stay.

The most common question is why do women stay. Before you show the introductory film, ask the participants to consider during the film why women stay. Also, ask them to see if they can get any clues about why men beat women.

With this introduction, show the film (see Appendix D for recommended films). After the film you can discuss why women stay and why men beat women.

C. Film Discussion and Questions

Why Women Stay

Mildred Pagelow suggests that there are three major elements which work to keep the woman in a violent situation:

1. A traditional sex role ideology.
2. Lack of personal resources (family, friends, job).
3. A negative or the absence of an institutional response when she does reach out for help.[7]

Emphasize that all relationships are on a continuum from respect to abusiveness. Each of us goes into a relationship hoping that it will be based on mutual respect. Unfortunately, many relationships do not turn out that way.

Some people will say, "yes, but if my spouse ever hit me, I would leave right away!" Have the participants think of the different relationships they have had with lovers, bosses, parents, friends. We have all experienced some abusive (not necessarily physical abuse) relationships. In their own cases, how did they decide when to get out of the relationship? Was it clear to them when it was time to leave? When to give up hope? Most of us have the experience of staying in a situation longer than we should, hoping that everything will work out. We have all experienced to a degree what battered women experience as they agonize over staying or leaving.

The following list includes many reasons why women stay:

1. Financial reasons — she cannot support herself (and family). She may not have a job. Women on an average earn 59¢ for every dollar that men earn. In 1979, 24% of female heads of home had incomes of less than $5,000 compared with 4% of married couple families.•
2. She feels that her children should grow up in a two parent family with the father present. The stereotypes about the horrors of growing up in "broken homes" continue.
3. If she does leave, the cost of childcare is prohibitive. In 1981, the cost of having one preschool child in full time daycare ranged from $180-280 per month! Also, there is not often adequate childcare readily available or accessible.
4. The task of bringing up children alone is frightening. If being a parent is one of the toughest jobs in the world, being a single parent is even more draining.
5. She is emotionally dependent on her partner. She may still love the man. She hopes for changes and believes that if she loves the man well enough, he will change.
6. She is isolated from family and friends. She may not discuss the abuse with anyone else. Often other people are uncomfortable with the subject of violence and don't want to discuss it. She may have no where to go — no one will take her in. As she becomes more isolated, she only gets feedback about herself from her partner. If he is abusive, her self-image will deteriorate.
7. The housing situation for a woman with children is dismal. Discrimination against children in the rental market is common and it is even worse for single parents and/or a parent on Aid to Dependent Children.
8. She is afraid of losing custody of the children. The abuser may threaten her with fighting for the children if she leaves.
9. She may stay within the marriage because of strong religious or cultural beliefs.
10. She may be literally a prisoner of the man. It is not uncommon for the man to keep the car keys with him at all times. He may drive her wherever she goes outside the home. He may keep the children with him whenever she goes out.
11. She may be terrorized into staying. The abuser may have vowed to kill her or her children or her family if she leaves.
12. She is afraid of what is "out there." At least she knows what it is like where she is. She isn't sure she can survive on her own.
13. She may fear that her husband cannot survive alone. He may commit suicide if she leaves.
14. She is likely to see it as her role as a woman/wife to make the marriage successful. To leave her partner would mean defeat — she would be a failure as a woman.

Why Men Beat Women

In discussing why men beat women, several issues are important.

1. He believes the sexual stereotype myth that the man should be the head of the household.
2. He may believe that he has to "discipline" his partner.
3. He is likely to be pathologically jealous, feeling that he must guard his partner continuously so that he won't lose her to another man.
4. He generally blames others for his own feelings or actions.
5. He may have been battered or witnessed violence between his parents as a child.
6. He may not know how to express his feelings. He generally is either quite passive or quite aggressive — doesn't know how to ask for what he needs.•

Stress to the participants that none of these reasons are acceptable excuses for beating another person. As adults, we are responsible for our own behavior. However, the man may see these as legitimate excuses for his behavior.

In general, men beat women because it is allowed in our culture. Men are taught from birth to hide their feelings outside of anger. Men are not taught how to ask for their needs. They learn to expect women to take care of their emotional needs. Until boys and girls are raised to be both strong *and* tender, to give *and* take, to be intellectually competent *and* emotionally nurturing, woman abuse will continue to be accepted or at least ignored in our society.

Introduction to Woman Abuse
Footnotes and References

[1] Langley, Roger and Levy, Richard C., *Wife Beating: The Silent Crisis* (New York: E. P. Dutton), 1977. p. 4.

[2] *New Light on an Old Problem*, Head Start Bureau, Administration for Children, Youth, and Families, Office of Human Development Services, U.S. Department of Health, Education and Welfare, 1978. DHEW Publication No. (OHDS) 79-31108. p. 5.

[3] Weber, Ellen, "Incest: Sexual Abuse Begins at Home," *Ms. Magazine*, May 1978.

[4] Langley and Levy, op. cit., p. 2.

[5] Langley and Levy, op. cit., pp. 33-34.

[6] Ibid., p. 38.

[7] Pagelow, Mildred Daley, "Secondary Battering: Breaking the Cycle of Domestic Violence." Paper prepared for presentation at the Annual Meeting of the Sociologists for Women in Society Section of the American Sociological Association, Sept. 5-9, 1977.

[8] Statistics gathered from Current Population Reports. p. 20. No. 363, *Population Profile of the United States 1980* and *Statistical Abstracts of the United States*, 1980.

[9] See Walker, Lenore. *The Battered Woman* (New York: Harper and Row, Publishers), 1979. pp. 35-41.

Session 2
Working With Battered Women: An Exploration of Values and Attitudes

Purpose

To give the participants an opportunity to explore their own values and attitudes around violence. This session is designed to confront the participants with violence in their lives and to help them begin to identify feelings similar to those held by abused women and children.

Agenda

I. Check-in. Short Comments on Homework Assignment
II. A Discussion with Battered Women
III. Break
IV. A Consciousness-Raising Exercise on Violence in Your Own Life
V. Societal Norms and Values Surrounding the Issue of Woman Abuse
    A. What it means to be female/male in our society
    B. A comparison between racism and sexism
    C. Battered women and battering men: the continuum of pain
    D. A challenge for all of us
VI. Evaluation

Objectives

At the end of this session, participants will be able to:

1. Relate at least two examples of battered women and their situations.
2. Identify a time when they experienced violence themselves and identify the feelings they experienced at the time.
3. Identify at least five societal norms and values which serve to perpetuate violence against women.

Notes to the Instructor

Necessary Equipment: Blackboard or flipchart
Handouts: None
Homework: Encourage participants to read the Straus article. (You might hand out copies, if possible.) Ask participants to think of a client they have seen who was involved in a violent family. What did they do? What questions did they have about the violence and working with her/him?

Evaluations

I. Check-in

II. A Discussion with Battered Women

Major Point #1: Battered women are not so different from you and me. They are trapped in a system created by societal norms, their own values and a family structure perpetuated by the violence.

The most effective learning tool for this session is to organize two or three battered women to come and informally discuss their own situations. You may find these women through a shelter program in your community, by word of mouth, or you may have to advertise. If you advertise, be prepared to pay the women for their time as a small incentive. It will be necessary to screen the women to find people who can communicate their situations well. It is probably best, although not necessarily imperative, that the women have been out of the violent situation for several months so that they have some perspective on what happened.

Keep this discussion informal. First have them give brief synopses of their situations. Then ask some questions:

- Why did you stay in the violent situation as long as you did?
- If you left and then returned, why did you return?

- What was the worst thing about leaving your abuser?
- What did you feel was the most helpful response you got from the community, family, friends, agencies?
- What changed your feelings of helplessness about ending the violence?

Encourage the participants to ask further questions.

III. Break

IV. Consciousness-Raising Exercise

Major Point #2: We have all experienced violence at some time in our lives and we have experienced the same feelings that battered women and children feel — guilt, shame, self-blame, fear, terror, rage, frustration, etc.

Have the participants sit in a circle (or circles) of ten or fewer people. Explain the rules for this exercise:

- Everything will be kept confidential. Nothing will be discussed outside of this group.
- Everyone is invited and encouraged to talk, but you may pass if you want.
- Give an idea of how much time you have for each person to share (approximately three minutes).

Ask everyone to take a few minutes to think of a time when someone was violent or threatened violence towards them. Then, in turn, ask them to share that experience and how it felt to them at the time.

In order to set an appropriate tone, you begin the exercise with an experience of your own. Remember, if you are willing to take a risk and share something more personal, it will be easier for the participants to do so. The deeper the level of experience you can tap, the deeper the level of learning that will take place. When you are done sharing, turn to the person next to you and say, "John, do you have anything to share?," and so on until you have completed the circle.

This exercise may bring up some strong feelings for some people. If so, let them know that having those feelings is O.K. Use your listening skills. If the person seems unable to come back to the group, ask them if they would like to be alone or go with someone to another room.

Leave a few minutes to process this exercise. Did they learn anything new from it? Were they able to connect more with battered women? What did they like or dislike about the exercise?

V. Societal Norms and Values

Major Point #3: Woman abuse is not simply an individual problem caused by individual sick men who prey on passive women. It is a problem caused in part by societal values and norms which encourage it. Until those values and norms change, there will always be battered women.

You want to examine what the differences are between being male and female in this society. You could put up two large sheets of paper and ask people to call out what comes to mind when you say the words masculine or feminine. Look at the differences.

- Relate the 1970 study by Broverman, et al., when college students were asked to identify traits of healthy male, a healthy female, and a healthy adult in three separate tests. The traits judged as those for a healthy adult were the same as those identified for a healthy male. The healthy female traits were different![1]

These attitudes cause ambivalence for women who want to be healthy, adult and female. Some of the adjectives used to describe feminine might be: nurturant (of others, not self), receiver (not seeker), passive (not active or doer), small (not taking up much space), emotional (not intellectual), intuitive (not rational), weak (not strong — the only strength generally thought of as feminine is that of withstanding pain, as in childbirth), quiet, soft (not loud or energetic).

Battered women are the ultimate feminine women, using our definitions of feminine. They are women who have bought the myths of femininity. The bargain that is struck between men and women is that the woman agrees to be all of these things and, in return, the man agrees to be strong, support her financially, and take care of her. In this bargain both men and women end up denying parts of themselves. For men it is their softer, emotional, tender, scared, sad parts that are squelched. Women must deny their strength, anger and power. The price we all pay is overwhelming. The battered woman may pay with her life. The battered woman is betrayed. She has attempted to be feminine, but instead of being protected she is abused. This abuse is both a violation and a validation of her femininity.

Sexism is a term that often arouses strong emotions. Your trainees may have difficulty accepting that this is an issue that needs confronting in this training. However, an effective treatment/intervention program for battering men and/or battered women must include a component on sexism. Without this awareness, men and women will be likely to repeat old patterns of relating in new partnerships without understanding why and without any encouragement to change.

One way which might make it easier for participants to understand is to draw a comparison with racism. We live in a racist society. Racism is the belief that one race is superior and has the right to rule others. Both white people and people of color are taught to be racist in our society. Oppressed peoples inevitably learn to dislike themselves and adopt the values of the oppressors to survive. For anyone to say they are not racist is absurd. Our society is racist. We don't even begin to realize the extent of our own racism because we are in the system. It isn't helpful to feel guilty about our racism, but it is important to be constantly confronting it in ourselves. In order to do that, we have to drop our defenses and open our eyes to totally new perspectives. We have to begin to recognize how racism permeates our society — our language, our economic structure, the legal/penal system, the medical system, etc. And we have to understand that racism hurts all of us — black, brown and white. In the same way, we need to confront our sexism. Like racism, sexism is the belief that one sex is superior and has the right to make decisions for the other sex. The first step is to be open to seeing it. Guilt closes doors; it doesn't open them. If your group is having a particularly hard time with this, you might want to schedule an extra session.

Some groups will not be able to identify with a discussion of racism. An exercise which sometimes helps is to divide the group by eye color. Brainstorm a list of superior traits of blue-eyed people and a list of inferior traits of brown-eyed people (or vice versa). Structure part of a session around this division. For example, let all the blue-eyes sit nearer to the instructor because they learn better, etc. Or, another exercise that might help is to get participants to talk about times when they felt discriminated against. What feelings does this produce? How did they react?

You might assign as homework Murray A. Straus's article, "Sexual Inequality, Cultural Norms, and Wife Beating."[2] Before counselors can adequately work with battering men or battered women they must have a grasp of the societal pressures which push men in roles of dominance and women into roles of powerlessness. That is why this session is so important to include *before* other sessions.

VI. Evaluations

Working With Battered Women: An Evaluation of Values and Attitudes

Footnotes and References

[1] Broverman, D. L.; Broverman, D. N.; Clarkson, F. E.; Rosenkrantz, P.; and Vogel, S. R. "Sex-Role Stereotypes and Clinical Judgements of Mental Health," *Journal of Consulting and Clinical Psychology*, 1970, *34*:1-7.

[2] Straus, Murray A. "Sexual Inequality, Cultural Norms, and Wife Beating," in *Victims and Society*. Emilio C. Viano, ed. (Washington, D.C.: Visage Press), 1976. Also in *Victimology*, 1 (Spring), 1976, pp. 46-76 and in *Women Into Wives: The Legal and Economic Impact of Marriage*, Jane Roberts Chapman and Margaret Gates, eds. Sage Yearbooks in Women Policy Studies, Vol. 2 (Beverly Hills, Ca.: Sage Publications), 1977.

Session 3
Working With Battered Women: Intervention and Treatment

Purpose

To teach participants some basic skills for assessing and counseling battered women.

Agenda

- I. Check-in and Review of Homework
- II. Who are Battered Women?
  - A. Common characteristics
  - B. Isolation syndrome
  - C. 3 Stages of violence
- III. Sam & Mary Role Play
- IV. Break
- V. Assessment
  - A. Asking about violence
  - B. What do you do when a woman says she's been beaten?
  - C. What therapists must do
  - D. W
- VI. Groups for Battered Women
- VII. Evaluations

Objectives

At the end of this session, participants will be able to:

1. List at least five common characteristics of battered women.
2. Identify at least three reasons why a battered woman would become isolated.
3. List the three stages of the violence cycle and identify a relationship they have or have had that has followed this pattern.
4. Formulate their own way of asking about possible violence.
5. List at least five important steps for a counselor to take when working with battered women.
6. Define at least four advocacy tasks often needed by battered women.
7. Identify at least three reasons for using groups for battered women.

Notes to the Instructor

Necessary Equipment: chalkboard or flipchart

Handouts: #2, 3, 4 in Appendix D; copies for all trainees

Homework: Ask participants to consider how alcohol and other drug abuse might overlap with family violence.

Evaluations

I. Check-in

II. Who are Battered Women?

Major Point #1: While battered women are not noticeably different from other women, they do have some common characteristics *as a result of the abuse.*

Go over with participants some common characteristics of battered women. This list is taken from Lenore Walker, *The Battered Woman.*[1]

1. low self-esteem
2. believes myths about battering relationships
3. traditionalist, prescribed sex role
4. accepts responsibility for batterer's actions
5. suffers from guilt, denies terror and anger
6. presents passive face to world; has strength to manipulate environment enough to prevent further violence and being killed
7. has severe stress reactions with psychophysiological complaints
8. uses sex as a way to establish intimacy
9. believes no one will be able to help her resolve her predicament except herself.

Other characteristics that often occur are:

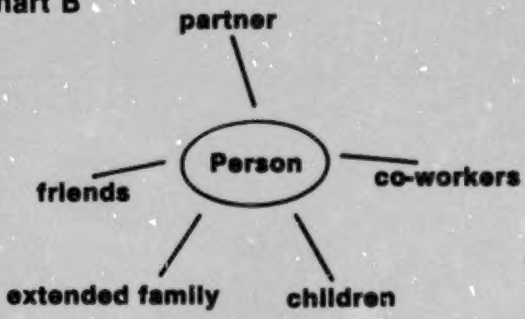
1. depression, often leading to use/abuse of prescribed medication such as Valium, Elavil, etc., or alcohol and other drugs
2. may be overwhelmed by parenting demands
3. generally more capable than she perceives herself
4. generally extremely isolated from family and friends.

Note again with participants how we are all on the abuse/respect continuum in our relationships – so all of us have these characteristics somewhat. Have them identify themselves on this list when they consider an abusive relationship in which they have been.

Major Point #2: The battered women's isolation from friends and family is one of her major stumbling blocks to making effective and lasting positive changes in her life.

Use the chalkboard or flipchart to make the following diagram:

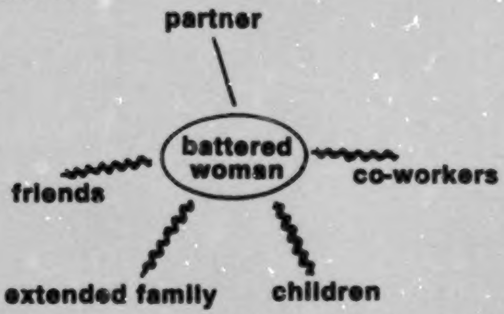
Chart B



As you draw it, explain how we each use the significant others in our lives to constantly give us feedback on who we are and how we are doing. With yourself, if you get negative feedback from one source (for example, your children say you are old-fashioned and unfair), then you can go to another source and check it out. You might go to a friend and ask their perception of you. This is how we validate ourselves and how we decide to make changes. If most of your significant others are concerned about your health, you are likely to check it out. A battered woman's diagram, however, looks more like Chart C.

The battered woman is likely to get feedback on herself almost exclusively from her partner. Often, her family has resisted her pleas for help, telling her to try harder or that it is important to stay in the marriage. ("You made your bed hard – you have to lie in it.") Or, the abuser may have insisted that she stay away from her family. He may claim not to like them or he may be jealous of her feelings for them.

Chart C



If she approaches her friends they may be incredulous, thinking she must be crazy to stay with him, not understanding the difficulties of her situation. Again, her abuser may refuse to let her spend time with her friends. Or, she may not even talk with her friends about the abuse because of shame or because she doesn't want them to get involved. The same issues occur with all the possible people who could offer her some feedback. Because of his verbal abuse, she may begin to believe that she is fat, ugly, stupid, that no one else would have her, etc. Women relate again and again how the verbal abuse is often worse than the physical abuse – the wounds lasting long after the physical wounds have healed. This isolation contributes to what Lenore Walker defines as learned helplessness: the person may have control over what will happen but believes she/he doesn't and responds with learned helplessness phenomenon.

Major Point #3: It will help both counselor and the battered woman to identify the three stages of violence in terms of possible future prevention of severe beating and treatment indications.

Lenore Walker identifies three stages of violence.[2] The first is the tension-building stage. Here, the partners become aware of incidents that are increasing tension in their relationship. This may involve some minor physical abuse such as shoving or squeezing the arm, building verbal and psychological abuse, and perhaps throwing o[illegible]king objects.

The se[illegible]tage is the acute battering incident. After [illegible]sion has built to a certain point, any minor occurrence can set off a beating. Immediately following this is often a period of shock.

The final stage is the one that will continue to hook women into staying — the calm and loving or "honeymoon" stage. As many battered women will testify, there are no beatings without roses. In this stage, the abuser is often quite loving, helping out more around the house, bringing flowers or candy, taking the woman out. Sometimes neither of them will mention the battery incident.

Throughout this discussion keep the participants aware of their own experiences with abusive relationships. Can they identify this cycle in their relationships? How long did it take them to go through the cycle?

One couple may go through all three stages in a day; another couple may take a year. Generally, the longer the violence has been occurring, the faster the couple will go through each stage. A therapist who understands these stages can help both the man and the woman begin to recognize the danger signals that lead to an acute battering incident. Since most women come for help immediately following a beating, the honeymoon stage is soon to follow. Women can be prepared for this and reminded that tension-building is not far behind. A woman who is able to resist the honeymoon stage and still insist that the abuser go and seek counseling is breaking an old pattern. This may be a very powerful impetus for the abuser to get help.

III. Sam and Mary Role Play

Role play: In this role play, you and a co-facilitator or friend will play out an evening in the life of Sam and Mary. Tell the audience: Sam and Mary are a middle-class married couple. Sam beat Mary the night before. They have 3 children: Sammy, Jr. (9), Missy (14), and Nellie (6). Now role play the following:

Sam comes home brnging flowers for Mary, apologizing for the night before. She is still a little scared, really trying to keep things calm this evening. He mixes himself a drink and flops down on a couch — a hard day at work. Mary has fixed his favorite dinner — roast. He is pleased. Asks about the kids. Chit-chat. Mary brings up that Missy needs his signature so she can take shop at school. He is furious — no daughter of his is going to take shop. That is for boys. Mary argues for a while, then backs down. More chit-chat.

Mary reports that they have been invited to an office party Saturday night. Sam is irritated — Saturday night is the night they have dinner with his mother. Mary wants to go. Sam says she doesn't know how to act socially and embarrasses him. Mary argues. She is lonely, wants to meet new people. Sam is furious again — starts yelling about how Mary always flirts with other men at parties. Says they are going to his mothers and that is final. Mary cowers.

They sit down to dinner with kids. They attempt small talk but tension is obvious. Sam is irritated by kids' table manners. Mary is extremely upset. Sam begins carving the meat and it is tough. He demands to know what she paid for it. She tells him. He explodes, saying he tried to be nice but she has ruined his evening. He threatens to hit her, changes his mind, picks up his plate of roast, throws it and stomps out.

Have Sam and Mary talk about how they felt in their roles. Ask for audience reactions. Could they identify the stages? This is a graphic way of illustrating the stages and the tension in the relationship.

IV. Break.

V. Assessment

Major Point #4: Violence is so prevalent that it is imperative for counselors to ask about it. The best way to ask is directly.

When you are counseling a woman for alcohol abuse, depression or whatever, and she is in a relationship, at least one question on physical abuse should be included in the assessment/intake form. "Does your partner ever hit, slap, or kick you or hurt you in any way?" If this exploratory question is answered affirmatively, then it will be necessary to inquire further. An example of important questions is in Appendix D (Handout #2) to be handed out to all participants. Go over these questions with the participants to make sure they understand them all.

Major Point #5: Once the violence is admitted, therapists and friends can follow several steps for working with battered women including listening to and believing her stories, supporting her sadness and her anger, giving her information on the problem, helping her develop alternatives to living in a violent home.

In crisis work with battered women, once you have determined that she is not in immediate danger, a most important first step for the counselor to take is to validate and support the woman. Praise her for her strength and bravery in reaching out for help. Next, listen to her stories. She may have never told anyone and she may need to talk about all the horrible events. As counselor, you need only to listen, validate how bad it must have been, and let her know that others have experienced similar horrors — she is not alone. Because battered women are often not believed, believing is one of your most important tools. Very few women will be making up stories. Most will attempt to minimize the violence out of misplaced shame. So you can overcome some of her denial by simply believing. Go over Handout #3 (Lenore Walker's list of what therapists must do) and #4 (Intervention With Women) with the trainees.

Major Point #6: Because of the sexism in the society and the misunderstandings about family violence, and the lack of self-confidence of the women, many battered women will need help in making necessary systems responsive to their needs.

Working with battered women does not mean simply doing individual therapy. Many of their needs can be met only by cooperating with other systems such as the police and courts, legal system, financial aid (social service system), medical system, and subsidized housing. As Lenore Walker says, the therapist must be willing to cooperate and untangle bureaucracy for unskilled clients (see Handout #4). But you must also be able to work as an advocate with systems that have been traditionally unresponsive to battered women. Frances Woods and Miriam Habib delineate four necessities for advocates for battered women in working with systems.

1. Recognize wife assault as a broad social problem which requires institutional changes.
2. Attempt to sensitize and form cooperative approaches with other agencies — courts, police, hospitals, etc.
3. Recognize and deal with the resistance there is to seeing wife assault as more than a family issue. Resistance will come in the form of trying to blame women and keep family together at all costs. Male authority of systems may be threatened, when the issue of battered women is raised.
4. A shelter for women needs to be set up. A stop gap measure is a shelter network of private homes.[3]

VI. Groups for Battered Women

Major Point #7: One of the best ways for working with battered women is through groups which minimize isolation, build skills of verbal negotiation, encourage new social groupings, and sustain support.

Groups work for battered women because they can see that they are not the only ones in their situation. Women are often amazed to hear others talk of their situations and see the similarities in the situations. ("It sounds like we are married to the same man!" you may hear.) Battered women are most likely to recognize each others' games and self-pity and call it for what it is. Hearing it from someone else, sometimes helps you see how ridiculous it is in yourself. Women who are out of violent situations can serve as role models for women who are still experiencing violence. Groups also encourage women to develop skills around verbal negotiation. They show women that they can be friends with other women — a whole different kind of intimacy for many battered women. Therapists who see several battered women should consider forming groups. Support groups may be loosely structured although it is important to have a facilitator or facilitators to model verbal skills and guide the group, especially in the beginning. Later on, a group could use a structure similar to Alanon for its meetings.

VII. Evaluations

Working With Battered Women: Intervention and Treatment

Footnotes and References

[1] Walker, Lenore. *The Battered Woman* (New York: Harper and Row, Publishers), 1979. p. 31.

[2] Ibid., pp. 55-70.

[3] Woods, Frances and Habib, Miriam, "Strategies for Working with Battered Women, Their Families and the Systems Around Them," Washington County, P.O. Box 1168, Fayetteville, Arkansas 72701.

Session 4
The Connection Between Chemical Dependency and Family Violence

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Purpose

To illustrate how the dual problems of alcohol and other drug abuse and family violence intertwine, to examine the similarities and differences between the two problems, and to begin to develop a treatment strategy for such families.

Agenda

- I. Check-in and Review of Homework
- II. The Incidence of Families with Dual Problems
- III. The Theories
  - A. Disavowal technique
  - B. Disinhibition theory
  - C. Learned behavior theory
- IV. Commonalities and Differences
  - A. Between the two problems on a family level
  - B. Between the two fields: AODA and family violence
- V. Break
- VI. Three Perspectives for Counselors
  - A. Addiction theory
  - B. Family system approach
  - C. Feminist theory
- VII. Treatment Indications
- VIII. Evaluations

Objectives

At the end of this session, participants will be able to:

1. Relate at least one statistic on the extent of the overlap between family violence and chemical dependency.
2. Cite and define the three theories on the connection between family violence and chemical dependency.
3. List at least three similarities and three differences between the two problems.
4. List at least two differences in background and approach between the two fields of family violence and chemical dependency.
5. Describe the three approaches necessary for counselors working with families that have both problems.
6. List at least five necessary steps in the assessment and intervention with families with both problems.

Notes to the Instructor

Necessary Equipment: Chalk board or flipchart

No handouts

Evaluations

Homework: Have the participants think of any cases they have had working with violent men. What difficulties did they have? What were the main issues?

I. Check-in

II. The Incidence of Families with Dual Problems

Major Point #1: There are a large number of families that are experiencing both alcohol and other drug abuse problems and family violence.

There are some statistics in Chapter I, page 2. You might include the following:

Child Abuse:

- Henry Kempe estimates that alcohol plays a part in approximately one-third of child abuse cases.[1]
- Mayer and Black, in a review of the few studies available on child abuse and alcoholism, conclude that from 32-62% of the families where child abuse occurred also had a parent who used alcohol dysfunctionally.[2]

Woman Abuse:

- Langley and Levy reviewed several studies on the association between AODA and family violence and estimate that 40-90% of spouse abuse cases are directly linked to alcohol abuse.[3]

Most existing research seems to support the conclusion that alcohol abuse does not cause marital violence. The link appears *not* to be one of cause and effect.

III. The Theories[4]

Major Point #2: Different theories on the connection between alcohol and other drug abuse and family violence may apply to different families. However, these theories are not overly important in terms of treatment plans.

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1. **Disavowal technique** — Some men may beat their wives because they know that by being drunk they will be released from responsibility both by their wives and girlfriends and by the rest of society. (Gelles, 1974)
2. **Disinhibition theory** — Alcohol acts to lessen inhibitions (Natalie Shainess, 1977), so that men who drink lose their inhibitions towards aggressive behavior. This theory, however, is not supported by available evidence, since most alcoholics do not beat their partners.
3. **Learned behavior theory** — Violence was acquired because of the social meaning attached to alcohol. Men who are violent when drinking have learned through cultural or familiar norms that violence and drinking go together. (Lang, et. al., 1975)

Coleman and Straus: "In summary, disinhibition theory states that one may become aggressive because of alcohol consumed, social learning theory states that people learn how to react to and behave under the influence of alcohol, and deviance disavowal and 'time out' theories state that an individual may drink so he or she can aggress."[5]

In general, alcohol abuse is more clearly associated with violence in the husband-wife or partner-to-partner relationship than in the parent-child relationship. Most recent research tends to place external influences such as alcohol abuse in a position of secondary importance to cultural and societal factors as causes of violence. However, since the overlap between the two problems is so great, it is very important to learn techniques for working with families that have both problems.

IV. Commonalities and Differences

Major Point #3: In working with these families it is important to understand the similarities between the two problems and the differences.

Jerry Flanzer, in "The Vicious Circle of Alcoholism and Family Violence," outlines the following similarities and differences.[6]

Similarities:

1. Resolves conflict
2. Forces reaction
3. Tolerated, learned
4. Blocks feelings, intimacy
5. Masks depression, pain
6. Different baseline/limit
7. Sexual stereotyping
8. Economic frustrations
9. Rigid family patterns

Differences:

Alcoholism	Family Violence
1. Different locations	1. Occurs in privacy of home
2. Act affects others secondarily	2. Act affects others primarily and secondarily
3. Building level of incidence	3. Quick, high level of incidence
4. Physical safety impaired	4. Physical safety endangered

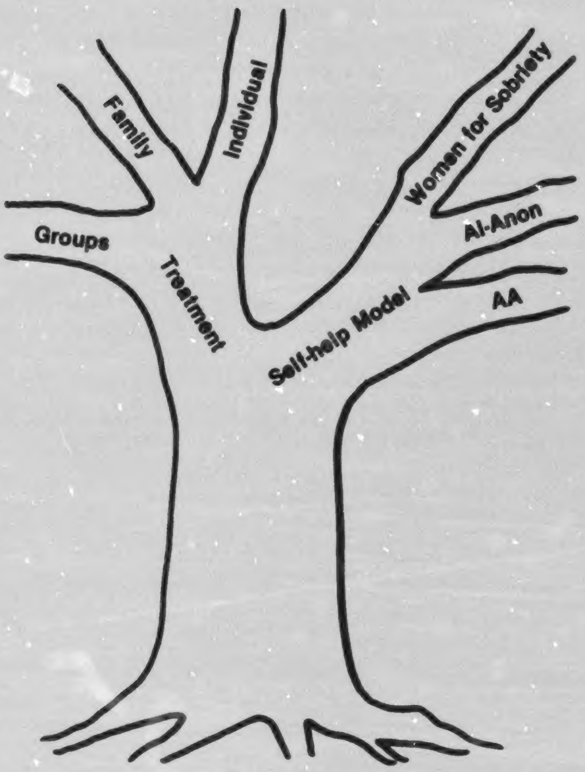
Some additional commonalities are the repetitive cycle of abuse from generation to generation and some of the personality characteristics of the alcohol abuser and the violent man. Also, there are similarities in the family systems. In both family systems, if the man is the abuser, the woman is likely to stay, accept some of the responsibility for the man's problem, and try to change the problem herself. This role, of course, originates in her upbringing which taught her that she was responsible for insuring a happy marriage and emotionally secure family.

Major Point #4: Because the two fields, the AODA system and the woman abuse system, grew out of very different roots it is easy for there to be misunderstandings. On the other hand, the two fields have much they can learn from each other because of these differences.

In the diagram of the family trees for the AODA system and the woman abuse system we can see the trees are rooted in very different theories. And yet these very differences mean that the two fields have much to teach and learn from one another. In particular, the whole disease model of the AODA field, which totally overhauled the former view of alcoholics as morally depraved, needs to be clearly considered by those in the woman abuse field. This concept takes the onus off the abuser and dissipates his/her guilt, making reaching out for help easier. The paradoxical approach of Alcoholics Anonymous (AA) may also be helpful when applied to violent families. The focus of Al-Anon on the affected partner redirecting responsibility for the partners' behavior to accepting responsibility for one's own behavior, is also a useful concept when applied to battered women.

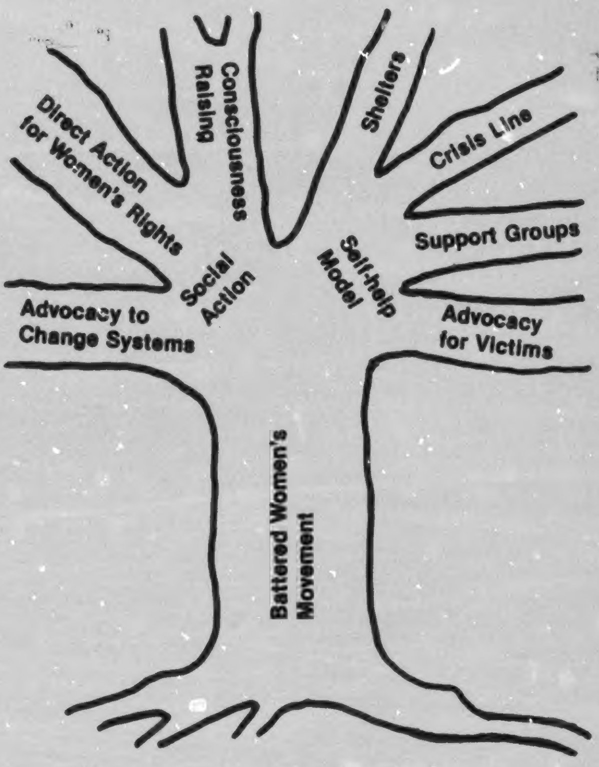
The emphasis of the woman abuse movement on political/socio-economic issues as underlying causes of the violence could be applied more frequently in the AODA field. AODA counselors are just beginning to examine more closely the differences between male and female abusers and their needs for somewhat different approaches to treatment. The availability of more women's AODA support groups testifies to this new approach. We may need to explore even more deeply to see in what other ways alcohol and other drug abuse is the outcome of twisted societal norms and attitudes. Change will not occur unless every social service movement has a social change branch.

AODA FAMILY TREE


Family
Individual
Women for Sobriety
Al-Anon
Groups
Treatment
Self-help Model
AA

Rooted in Medical Model and Social Services

WOMAN ABUSE FAMILY TREE


Direct Action for Women's Rights
Consciousness Raising
Shelters
Crisis Line
Support Groups
Social Action
Self-help Model
Advocacy to Change Systems
Advocacy for Victims
Battered Women's Movement

Rooted in Women's Movement and Social Change

V. Break

VI. Three Perspectives for Counselors

Major Point #5: Counselors working with families with both AODA and violence need to approach the problems as addictions, as family systems and from a feminist perspective.

The addiction theory is well described by Miriam Ingebritson of the Family Renewal Center in Minneapolis, MN. She defines chemical dependency as, "a pathological relationship to a mood altering chemical." Sexual and other abuse is "a pathological relationship to a mood altering experience."[7] Jerry Flanzer writes, "For, like the disease of alcoholism, whose pathology it so closely follows, intra-family violence is also a disease, primarily a psychological and social one."[8]

A counselor who is working with these families that are dually addicted would do well to understand addictions and how they work.

The family systems approach is also important to use with these families. The systems approach entails a change in perspective from looking at the individual as part of a relationship which functions according to patterns and rules. Using this approach, a counselor would attempt to work with the whole family or as much of it as possible. Members of the family or the family as a whole need to identify and confront the family rules and patterns that are destructive and begin to change these behaviors and attitudes.

Thirdly, a counselor needs to help these men and women identify the societal norms which allow and even encourage both of these abuses. Clients' changes will endure when they are rooted in value changes. Men and women who honestly examine societal values around rearing boys to be tough, and rearing girls to be nurturing and passive, adult male and female roles, as well as society's values on using chemicals to cure all emotional problems, will have a deeper understanding of their own reactions. They will also be better able to rear their children with healthier values and attitudes to prevent the repeated cycle of violence and alcohol and other drug abuse.

VII. Treatment Indications

Major Point #6: Counselors working with AODA related violent families should keep in mind the following issues.

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1. *Ask* about both violence and AODA in every intake/assessment.
2. Involve the whole family (although not necessarily together) in the treatment program — or as much of it as possible.
3. Because these spouses are generally so pathologically dependent on one another, it often helps to disrupt the family. Separating the partners for at least a period of time encourages independence, shows the partners that they can survive without one another, forces a reduction in the isolation from others and allows the woman/children to be safe from the violence.
4. The order for treatment of dually addicted families is:
    a. Get everyone in a safe place.
    b. Begin treatment for alcoholism and/or other drug abuse.
    c. Before the AODA treatment ends, begin treatment for violence.
    d. Provide ongoing support for both sobriety and the continued cessation of violence.

VIII. Evaluations

The Connection Between Chemical Dependency and Family Violence

Footnotes and References

[1] Hindeman, Margaret, "Child Abuse and Neglect: The Alcohol Connection," in *Alcohol Health and Research World,* Vol. 4, No. 1, Fall, 1979. p. 2.

[2] Coleman, Diane and Straus, Murray A., "Alcohol Abuse and Family Violence." Paper presented at the American Sociological Association Annual Meeting, February, 1979. p. 3.

[3] Langley, Roger and Levy, Richard C., *Wife Beating: The Silent Crisis.* (New York: E. P. Dutton), 1977. pp. 71-73.

[4] Coleman and Straus, op. cit., pp. 4-6.

[5] Ibid., p. 6.

[6] Flanzer, Jerry, "The Vicious Circle of Alcoholism and Family Violence," in *Alcholism,* January/February, 1981.

[7] Carnes, Pat and Ingebritson, Miriam, "Family Sexual Abuse: Philosophy of Treatment," available from Family Renewal Center, Fairview-Southdale Hospital, 6401 France Ave. So., Minneapolis, Minnesota, 55435, (612) 920-4400.

[8] Flanzer, op. cit., p. 30.

Session 5
Working With Men Who Batter*

Purpose

To introduce participants to some techniques for working with violent men as well as some understanding of the dynamics leading to the violence.

Agenda

I. Check-in and Review of Homework
II. Causes, Myths and Characteristics of the Abuser
III. Detecting Abuse
  A. Intake/assessment tool
  B. Enhancing motivation for treatment
    1. Empathy and confrontation
    2. Exploring resistance-fears about getting help
    3. Contracting
IV. Treatment Indications
  A. Pros and cons of working with couples versus individuals
    1. Different dynamics
  B. Batterers Anonymous—self-help
  C. Treatment groups
    1. Assertiveness
    2. Progressive relaxation
    3. Consciousness-raising
    4. Cognitive restructuring
V. Break
VI. An Exercise in Cognitive Restructuring
VII. Interventions — What Helpers Must Believe
  A. Refer
  B. Control
VIII. Evaluation

Objectives

At the end of this session, participants will be able to:

1. Identify at least three ways that society encourages men to be violent.
2. List at least five common characteristics of men who batter.
3. Recite at least three appropriate questions to ask in assessing violence.
4. Identify three techniques to motivate men to seek or continue with treatment.
5. List at least three reasons why groups are effective for men who batter.
6. Use cognitive restructuring in a situation they have experienced personally.
7. List at least three requirements for helpers to believe when working with men who batter.
8. Write up a control plan for a man who batters.

Notes to the Instructor

Necessary Equipment: Chalkboard or flipchart
Handout #5 in Appendix D

Evaluations
Homework: None

I. Check-in

II. Causes, Myths and Characteristics of the Abuser

Major Point #1: Woman abuse is so common that it cannot be blamed on the isolated acts of a few sick men. The causes of woman battering lie in society's acceptance of violence within intimate relationships and the individuals' acceptance of a rigid male sex role stereotype.

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*This session was originally planned and presented by Steve Wilson, Alternatives to Aggression Program, Family Services, Madison, Wisconsin.

According to Frances Purely and Norm Nickle, "Men who batter are victims of domestic violence. They are victimized by their own lack of communication skills, fear of intimacy and dependency on the women they batter. They are further victimized by a society that trains men to be inadequate through a rigid support of a male sex-role stereotypic behaviors. Men who batter are the products of a society that trains men to be 1) unaware of their own feelings, 2) dependent on women to take care of feelings in the family or relationship, 3) problem and action oriented as opposed to process oriented, and 4) programmed that anything less than perfect behavior is failure."[1]

Battering men are not necessarily psychotic. Many are considered "nice guys" by the majority of their associates. Batterers come from all classes, races, and educational backgrounds. The violent man may have all or some of the following characteristics:

1. Rigid, stereotyped sex role.
2. Low self-esteem.
3. Idealization of the marriage.
4. Likely to have been a victim of child abuse.
5. Likely to have witnessed violence between his parents.
6. May abuse and/or neglect his children.
7. Rigid family boundaries.
8. Inadequate parenting skills.
9. Poor communication skills/patterns.
10. Socially and emotionally isolated/withdrawn.
11. Extremely dependent and/or possessive of partner.[2]

III. Detecting Abuse

Major Point #2: Because of the extent of woman abuse, men who come for counseling who are in relationships should be asked about their violence.

If the counselor gets a positive answer to a general question, such as, "Have you ever slapped or hit or pushed your partner?" or if the man shows a lot of discomfort with the question, then the counselor needs to explore the issue more thoroughly.

Go through the assessment tool, Handout #5, Appendix D, with the participants. You could point out how the questions on the last two pages begin by addressing less violent incidents and build to incidents involving major violent acts.

Major Point #3: Because most abusive men do not seek out help to change their violent behavior, the counselor may have to work at motivating such men.

There are three techniques a counselor can use to enhance the man's motivation. First, the counselor can use a mixture of empathy and confrontation. The empathy is important to remove the abuser's sense of isolation and to gain some sense of trust. However, the counselor also needs to confront negative or unreasonable behavior or thoughts. Here are two examples of how this method might work:

Therapist-Client Dialogue Combining Empathy and Confrontation:[3]

Man: She was probably out chasin'. I caught her once with a man.
Ther: You thought she was with another man, and you felt upset and angry. (empathy) Even if she was, what you did to her was clearly against the law. (confront)
Man: She deserved it! If she wants to leave, good riddance!
Ther: Does it upset you to think of her leaving you? (empathy)
Man: Ya, it's like I don't know what's happening.
Ther: You seem to let your fears get to you, then you boil over and want to control her.
Man: Ya, sometimes my mind goes pretty far out.
Man: I wouldn't have done it if she'd kept her mouth shut.
Ther: Were you hurt and angry that she brought up your job? (empathy)
Man: You bet!
Ther: It's OK to have those feelings (empathy), but it's not OK to hit her. (confront)
Man: Well she knows what hurts me and I warned her.
Ther: You probably know the weak spots of your partner (empathy), yet you can learn not to let her get to you. (confront)
Man: I suppose. I never thought hitting was right.

Secondly, the counselor can spend some time with the man exploring his resistance. What are his fears about getting help? Will it make him feel like less of a man? What if he does *not* change his behavior — what are his fears in that case?

Thirdly, the counselor can contract with the man for a limited number of sessions. The contract can be useful in increasing a person's commitment to therapy.

IV. Treatment Indications

Major Point #4: The abusive man will generally need individual counseling and/or peer group counseling *before* couple counseling can be effective.

According to Lance C. Egly, when a man is violent, couples counseling can be dangerous for his partner.[4] He may use what she has said in the sessions against her at home. She may be afraid to be honest. Focusing on couples communication may encourage the abuser to refuse responsibility for his own actions; only separately can the man sort out his own needs and responsibility. The extreme dependence of the couple may also inhibit progress. These couples need to realize that they can function independently.

At a later point, when the man is controlling his violence and the woman is no longer afraid, they will benefit more from joint counseling.

Major Point #5: Self-help groups for battering men are important adjuncts to treatment or treatment in themselves.

J. M. Goffman has written a manual called *Batterers Anonymous: Mutual Support Counseling for Women-Batterers* that is available through CPAWC, P.O. Box 29, Redlands, California.[5] This booklet describes a method for establishing and conducting a self-help group for batterers.

The self-help group offers the man who batters a place to be with other men who are acknowledging and actively working on their violence problem. He will have models of men trying to change. He will be able to see that they are still men, not sissies, or hen-pecked excuses for men. He can begin to examine his behavior honestly without fear of ridicule. He will also be assigned to a buddy who he can call anytime. He has no need to feel in a one down position with a peer. Peer groups such as AA and Al-Anon have been proven effective treatment for addictions. Batterers Anonymous is one of a growing number of such peer groups organized to replace an addition with positive, healthy behaviors and thoughts.

Major Point #6: Structured groups for batterers which teach specific skills such as assertiveness, progressive relaxation, and cognitive restructuring are helpful. Such groups can also explore rigid sex roles and how they adversely affect men and women and their relationships.

Battering men may be either generally passive or aggressive. They may be passive men who quietly accept insults, extra work, other burdens, etc. and then come home and erupt at their partners. Or they may be aggressive and demanding everywhere, simply saving the actual physical violence for their partner. Teaching assertiveness skills can help these men learn how to ask for what they want and need, and convey that they have a right to have needs just like anyone else. Of course, no one will always get what he/she wants. However, assertive behavior means a person will get what he/she wants more often than if he/she is either passive or aggressive.

Progressive relaxation skills are taught for the men to use when they feel anger building. Progressive relaxation, involving tensing certain muscle groups and then releasing them, is a simple technique to learn and teach. These may be practiced every day at home or work until they become automatic.

Cognitive restructuring involves becoming aware of self-defeating thoughts and restructuring them into self-enhancing or positive thoughts. For example, a man and woman attend a wedding together. After the wedding, as they are leaving, she says she has to use the bathroom and runs back into the church. He waits. As he waits longer and longer he starts getting angry. He begins to wonder why he is waiting outside for her like a little puppy dog. He begins to imagine that she is with another man, making plans for a date. The angrier he gets, the more far-fetched his imagination goes. Finally, he has worked himself into a fury. He stomps into the church, finds her talking with another woman, screams at both of them, creating a scene and then hurries his female partner out of the church, berating her all the way.

In a group setting, this man could reprocess his thoughts and consciously try to change his negative thinking.

He is waiting outside the church. He is beginning to get angry, feeling like a puppy dog waiting for his master. He imagines she might be inside with another man. Then he stops this process, takes a deep breath. He reconsiders. He and his partner have a good relationship; they love each other. Probably they had a misunderstanding. He is then able to go into the church and talk to his partner. He assertively tells her that he felt like he waited too long for her. Then she can respond undefensively, apologizing or explaining what happened.[6]

V. Break

VI. Exercise: Identifying Self-Thoughts

Have the participants think of a time when they became angry. Ask them to identify their self-defeating thoughts at that time. Have them try to restructure their thoughts with the person next to them. (Trainer will need to explain how to restructure their thoughts.)

VII. Interventions

Major Point #7: Helpers must have certain values to effectively counsel battered men.

Purdy and Nickle outline the following requirements for helpers to believe:

1. The abuser is solely responsible for his own violence and abuse. The abuser may be provoked but he chooses to use violence as a way of handling the situation.
2. Once the abuser uses violence to cope with stress, he will rarely stop using violence spontaneously. Violence is addictive.
3. Violence is a learned behavior, learned through the culture. The more the family believes and practices the principles of this culture, the more likely the individual is to learn this behavior.
4. In counseling, the problems of the relationship cannot be the initial focus. Couple counseling cannot be effective until the partners are safe from being abused.
5. Group counseling is probably more effective than individual counseling. Groups lessen shame, guilt, and isolation and provide positive role models.
6. Group leaders must be aware of their own attitudes and experiences with violence.[7]

Major Point #8: If there are groups for violent men in your community, referring to them is probably most helpful.

Since groups for battering men appear to be most effective, referrals to those groups should be made whenever possible.

Major Point #9: If there are no groups for battering men in your community or if the man you are working with refuses to go, then you can still work with him, using the techniques described. Begin with a control plan.

Even in one session with a violent man you can give him some tools to begin controlling his violence. In this session, write up a control plan. Have him identify some cues that occur when he is getting angry and potentially violent, such as tightness in back of neck or chest. Then develop alternatives to violence. When he recognizes his anger building, he can take a deep relaxing breath and use a coping statement (i.e. "I can handle this situation. If I lose my temper I won't accomplish anything"). Then he can explain to his partner that he is getting too angry, that he is going to take a "time-out," but that he will be back in _____ minutes. It is important that he let his partner know when he is coming back so that she is not left wondering. In this time-out, he should agree to do something positive for himself. Jogging, working in his basement workshop, walking, working out in a gym, are examples of behaviors which can be done during a time-out. He should *not* go to a bar and drink or go driving. Then when he has gained control of his anger, he can return to discuss the original issue with his partner.

Example Control Plan

1. I can recognize my anger is building by ________

____

2. At this point I will take a deep relaxing breath and use my coping statement.
3. Then I will take a time-out. I will tell my partner when I will be back. During my time-out I will __

____

____

4. I agree not to drink, use other drugs, or drive during my time-out.
5. After my time-out, I will return to discuss the issue with my partner.

VIII. Evaluations

Working With Men Who Batter

Footnotes and References

[1] Purdy, Frances and Nickle, Norm, "Practice Principles for Helping Men Who Batter." ©1981, Washington State Shelter Network, 1063 S. Capital Way #217, Olympia, Wa. 98501. (206) 753-4621.

[2] Barnett, Pittman, Ragan, Salus, *Family Violence: Intervention Strategies,* U.S. Department of Health and Human Services, Office of Human Development Services; Administration for Children, Youth, and Families; Children's Bureau; National Center on Child Abuse and Neglect, DHHS Publication No. (OHDS) 80-30258 Issued May 1980, p. 12.

[3] Saunders, Daniel, "Alternatives to Aggression Program" ©1979. Family Services, 214 N. Hamilton, Madison, Wisconsin 53703, (608) 251-7611.

[4] Egley, Lance C. "A Shelter-Based Group Counseling Plan for Men Who Batter," %1981. Lance C. Egley. Available through Men's Place, Box 1582, Madison, Wisconsin 53701.

[5] Goffman, J. M., *Batterers Anonymous: Mutual Support Counseling for Woman-Batterers,* CPAWC, P.O. Box 29, Redlands, California.

[6] The structured group components mentioned are described in D. G. Saunders, "The Structured Group Treatment of Male to Female Violence," *Behavior Group Therapy,* Vol. 2, No. 3, 1980. pp. 2-9.

[7] Purdy and Nickle, 1981, op. cit. pp. 1-2.

Session 6
Legal Issues of Working With Battered Women*

Purpose

To expose the participants to some of the difficulties that battered women encounter within the legal system and to explore some possibilities for legal reform.

Agenda

- I. Check-in
- II. Background
  - A. Overall considerations
  - B. Legislation
  - C. Problems
- III. Legal System Response
  - A. Police response
  - B. District attorney response
  - C. Court response
- IV. Break
- V. Shelter Advocacy Programs
  - A. Services to battered women
  - B. Community education
- VI. Discussion of Cases—Homework Review
- VII. Evaluations

Objectives

At the end of this session, participants will be able to:

1. List at least two examples of how the legal system has been based on sex discrimination.
2. List at least three ways in which battered women are not protected under the present laws.
3. Explain at least three differences between the civil restraining order and the Chapter III restraining order.
4. Identify at least three possible remedies to the lack of adequate protection under the law for battered women.
5. List at least three reasons why an advocate may be necessary to help a battered woman untangle the legal system.

Notes to the Instructor

Necessary Equipment:	Chalkboard or flipchart Handout #6, Appendix D Evaluations
Background work:	For this session the instructor needs to do research on the legal systems in his/her community. You might want to call the police and district attorney's office and ask: 1. What are your policies around domestic violence? 2. Can you estimate the number of cases you see in a year? 3. What problems do you have with domestic violence cases? 4. What are the laws around domestic violence? 5. (If you are in Wisconsin) How do you process Chapter III restraining orders?
Homework:	Have the participants think of problems/cases they have had working with children from violent homes.

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*This workshop was originally planned and presented by Nancy Gustaf, Legal Systems Advocate, Dane County Advocates for Battered Women, Madison, Wisconsin.

I. Background

A. Overall considerations

Major Point #1: Sexism is historically grounded in both law and custom in this society.

- "Yes, wives, be in subjection to your husbands" — *New Testament I*, Peter 3.
- All of the great religious works — Bible, The Talmud, The Koran, The Book of Mormon — put men above women and give men the authority to dominate.[1]
- Throughout history in many societies men, but not women, had the right to own property, to vote, to divorce, to inherit wealth and titles.[2] Langley and Levy write, "The existence of civil and religious laws giving men superior rights over women nurtured the belief — born in the dim past in the smoke filled caves of primitives — that men also had the right to beat their wives."[3]
- Laws have improved slowly. During the 15th century it was still legal for men to beat their wives, but "severe violence" and "extreme brutality" began to be considered bad form.[4] Slowly, restrictions were put on the form beatings could take, such as a maximum of three strokes, or the thickness of the stick had to be less than the thickness of the husband's thumb ("rule of thumb"), or a man could not beat his wife at certain times, such as Sunday mornings.
- Women have traditionally lost all independent rights at marriage. The legal concept was that when two people married, they became one in the eyes of the law — and that one was the husband.[5]
- Sue Eisenberg and Pat Micklow in their study, *The Assaulted Wife: Catch 22 Revisited,* conclude, "Although present laws may be adequate, their applications were found to be misleading and inconsistent to victims seeking aid, and thus, assaulted wives are assured of little or no protection from violent husbands."[6]
- "It has been more than 200 years since the learned jurist Blackstone declared wife beating 'antiquated,' but neither the custom nor the attitude that fostered it is gone."[7]

Major Point #2: The criminal justice system's function is for incarceration and punishment, not rehabilitation.

One can simply look at the methods to confirm this point. People in jail rarely receive counseling or social skills training or addiction treatment. Punishments that fit the crime are rarely forthcoming. Philosophies on parenting expound new ways of shaping, guiding and controlling children, but very few new systems of rehabilitating prisoners are being implemented.

Major Point #3: Victims and witnesses generally do not get the support they need when they are involved with the criminal justice system.

A battered woman may feel powerless and intimidated by the system and therefore not follow through. Or battered women may fear reprisals by the perpetrator of the violence and not follow through. The battered woman may have legal rights now but she has little help to untangle the web of paperwork and bureaucracy. For a woman who has been isolated, dependent, and constantly reminded that she cannot possibly live on her own, the legal system presents a very intimidating and, at times, impenetrable situation.

If you add to that the fact that the battered woman often has no protection from the abuser while she engages in this legal battle, it becomes understandable why many women back out.

Major Point #4: Battery is a criminal offense—in a spousal relationship or otherwise.

On the other hand, the law does support the woman's (and everyone's) right to live free from battery. Some people, including batterers and their victims, are not aware of this fact.

B. Legislation

Major Point #5: Laws are not cut and dried. There is a lot of discretion by the police and the district attorneys in interpretation of laws.

As we have seen, laws change slowly, but they often change faster than individual attitudes. Police work, like almost all jobs, calls for individual discretion. What one police officer sees as disturbing the peace another sees as simple rowdiness. A police officer or a district attorney brings to work with him/her his or her own set of values and attitudes. If the police officer feels that a man has a right to privacy in his own home, he/she will react differently to a domestic violence call than an officer who has a special abhorrence of any kind of violence. And we cannot forget that there are police officers, and district attorneys, and judges, and lawyers who also beat their wives and partners.

Major Point #6: While the Wisconsin Domestic Violence Abuse Law of 1980 takes some of this individual discretion away, it is not a panacea to ending the problem—no legal reform can end the abuse.

In Wisconsin, in 1980, the Legislature passed the Domestic Abuse Law—an acknowledgment that domestic violence does exist. The goal of the law is to prevent further abuse. It legislates some money for shelters for battered women and community education. It calls for specific police training. And, it makes available to physically abused women a restraining order/injunction that carries with it a criminal penalty. If it is violated, the police must arrest the batterer. Handout #7 explains this restraining order more fully.

C. Problems

There are problems with this new law, however. First, a single woman with no children cannot get a Chapter 111 restraining order even though she is being physically battered by her partner. The Chapter 111 restraining order specifically protects only married women or single women with children.

Secondly, the processes for getting procedures set up for filing the injunction in many counties are inconsistent or non-existent. The trainer should call the district attorney's office in his/her county to find out what the procedures are there.

Thirdly, this restraining order does not cover threats of abuse and thus many women remain in dangerous positions.

The trainer should do research on the legal system in his/her community and state (if other than Wisconsin) to determine what is happening for battered women there.

III. Legal System Response

A. Police Response

Major Point #7: The police response to domestic violence is ambivalent.

The police, as has been pointed out, have no consistent response to battered women. In the past, domestic violence was seen as non-criminal and therefore not real police work. Often, police don't know how to handle the situation due to lack of training. Ironically, domestic violence calls are the most dangerous for police. An FBI study for an 8 year period showed that 20% of the total number of police officers killed in the line of duty died while answering disturbance calls, the majority of which are family disturbance calls.[8] The police officer may also be surprised to be attacked by the woman at his/her arrival. The battered woman, suddenly overcome with fear of reprisal at having called the police, may take her abuser's side when the police arrive or a third party (e.g. neighbor) may cause both parties to see police as intruders.

The police generally have an agency policy of no arrests in domestic violence cases. As Langley and Levy put it:

The current approach to family calls is in effect stacked in favor of the attacker. The police come, and nothing happens to help the battered woman. The cops tell her of the perils of the legal machinery, the trouble it will cause, quiet her down and leave. The net effect is that the woman's cry for help has been rejected. She's been told it's not a real problem. The husband's position has been reinforced. The inaction by the police says to him, 'We're here because we were called, but we don't think this is serious. We're *here to patronize your wife.' He knows that if he were really breaking the law—stealing a car or attacking property—then the cops would arrest him.*[9]

Some possible remedies to this ambivalence would be to have a more consistent policy when answering domestic violence calls and more training on defusing domestic violence calls. Also, if the police kept better statistics, separating domestic disturbance from domestic violence calls, they might begin to understand the extent and seriousness of the problem.

B. District Attorney Response

Major Point #8: The district attorney's response is also often ambivalent or so slow that the woman cannot follow through.

The battered woman must convince the district attorney to take her case. He/she may refuse to prosecute for many reasons.

1. Not enough evidence in his/her estimation.
2. Cannot be sure that a crime was committed.
3. Lack of witness(es).
4. Feels he/she will not be able to win the case.
5. Feels that woman doesn't have the commitment to follow through the trial.

The DA may feel that battery cases are a waste of time as women in the past have failed to follow through. Also the time to process a case (3-6 months) is long and drawn out. The district attorney may recognize that this will keep the woman in an unsafe place for a long time.

Some possible remedies:

1. Deferred prosecution.
2. Put more pressure on the DA to prosecute in order to show abusers that their behavior will not be tolerated.
3. Establish a post sentencing program of mandatory counseling rather than jail time or fine.
4. Charge the batterer—plea bargain for lesser charge if batterer agrees to mandatory counseling.

C. Court Response

Major Point #9: The court response is generally ineffective as a deterrent or as protection.

If the abuser is prosecuted, penalties are generally minimal and may not give a strong message to the perpetrator. For example, in Dane County, Wisconsin, a Battery charge is a Class C misdemeanor which carries 30 days in jail and/or a $500 fine. The fines are generally ineffective and may hurt an already financially burdened family. Also, the judge may refuse to try a case, recommending that the parties get a divorce instead. The court situation may intimidate the woman and create more tensions for her. And finally, the outcome at sentencing is not always satisfactory. The judge may not order any kind of counseling.

Some possible positive changes might come from educating judges about the problem and creating options for judges to use in sentencing. A higher court could also be used to overrule judges if they refuse to try a case.

IV. Break

V. Shelter Advocacy Programs

A. Services to battered women

Major Point #10: A battered woman will often need an advocate to help her sort through her legal options and help her untangle the complexity of the legal system.

Shelter programs which provide advocacy services for battered women are often most effective. The advocate has some flexibility to go with the woman through the system. The advocate also hopefully has established relationships with the police, DA and courts. An advocate can provide counseling, advocacy and information on the issues surrounding divorce, and on criminal issues. Most shelter programs also provide some community education including training for the police, district attorneys, judges and lawyers on domestic violence, and public speaking to various other groups.

VI. Discussion of Cases

This is the time for participants to share some cases they have had and to ask questions. You can break into smaller groups or discuss the cases with the whole group. Participants may want examples of what advocates do, so some prepared with a few cases of your own.

VII. Evaluations

Legal Issues of Working With Battered Women

Footnotes and References

[1] Langley, Roger and Levy, Richard, *Wife Beating: The Silent Crisis,* (New York: E. P. Dutton), 1977. p. 31.

[2] Ibid.

[3] Ibid., p. 31-32.

[4] Ibid., p. 33.

[5] Ibid., p. 35.

[6] Eisenberg, Sue E. and Micklow, Patricia L. "The Assaulted Wife: 'Catch-22' Revisited." Revised version, *Women's Rights Law Reporter,* Vol. 3-4, Spring-Summer, 1977. Rutgers University School of Law, Newark, New Jersey.

[7] Langley and Levy, op. cit., p. 42.

[8] Ibid., p. 165.

[9] Ibid., p. 161.

Session 7
Working With Children From Violent Homes*

Purpose

To emphasize that children from violent families, whether or not the violence is perpetrated on them, are adversely affected by that violence and need intervention addressed to their situations. Some specific ideas for working with children will be outlined.

Agenda

- I. Check-in (discussion of homework assignment will be done under VI A on agenda).
- II. Understanding of Family Systems
  - A. Nature of human existence
  - B. Nature of change
- III. Philosophical Underpinnings
- IV. Break
- V. What We Know About Families in Which Woman Abuse is the Presenting Problem.
- VI. Programs for Children
  - A. Assessment tools
  - B. Workshops
  - C. Kids meetings in shelters
    - 1. Role play—happy, sad, mad.
- VII. Evaluations

Objectives

At the end of this session, participants will be able to:

1. Identify that working with children means working with the whole family system and that change occurs through contradiction.
2. List at least five facts that we know about families in which woman abuse is occurring.
3. Identify at least four kinds of groups to use for intervention with children and describe their general purposes.
4. Describe at least three ideas for topics or activities for kids' meetings and at least three ideas for topics or activities for kids' workshops.

Notes to the Instructor

Necessary Equipment:	Chalkboard or flipchart.
Handouts:	#7, 8, 9 in Appendix D. Evaluation forms.
Homework:	Have each participant bring in an example of a child abuse/neglect or incest case he/she has worked with.

I. Check-In

II. Understanding Family Systems

Major Point #1: We are all interactive beings. We exist within and act and react as part of many systems. Behavior cannot be explained separately from these systems.

To go into this point in depth would require a whole course on family systems. Encourage people to think about the different systems to which they belong—family, extended family, co-workers, religious affiliation, sports teams, etc. Do they act differently in each group? Are there different rules and norms of behavior in each one?

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*This session was originally planned and presented by Mary Boncher, Family Advocate, DCABW. Ms. Boncher has written a project report on assessment of and intervention with children from violent homes. "314 D: A Short Term Intervention Project with Children Residing at a Shelter for Battered Women."

Major Point #2: Change occurs when there are contradictions in the system. Through correct understanding of the system and practice, we can direct our changing toward growth-oriented possible futures.

This is simply a theory of how change happens. For example, families go through stages of development moved by the contradictions of children and adults getting older and having new needs. Most families are not in the habit of examining their rules and contradictions, but we can teach families to do this so they can make desired changes.

III. Philosophical Underpinnings

Major Point #3: The programs for children outlined in this session are based on the beliefs that people can learn and change and that children are their own agents, largely responsible for their own life energy. The children's program described sees children as part of a family system, learning through it and acting as part of it.

When working with children, counselors need to pay attention to the following philosophical perspective:

1. Women abuse is not only a problem of individual women and their children or merely of a family, but of a complex system of economic, judicial, religious, cultural, social, medical, sexual realities in this country. These affect women as a "class" and children as a "class."
2. One of the major goals of working with men, women and children from violent homes is empowerment. Empowerment has two faces—individual and group. Individual empowerment means being able to express all of one's feelings non-violently but so they can be heard. It means being able to ask for what you want and need (but not necessarily always getting it), and taking responsiblity for one's own actions but not taking responsibility for anyone else's actions. Individual empowerment means respecting oneself and others.

   Group empowerment occurs when a disenfranchised group sees the commonality of their oppression, defines their unity, and directs energy towards taking power to accomplish a common goal.
3. The tools used by those involved in teaching this process of change need to be consistent with these philosophical goals in both process and content.
4. For these reasons, peer self-help groups are a powerful and effective tool in the process of empowerment. Modeling is one of the most effective teaching methods for both children and adults.

IV. Break

V. What We Know About Families in Which Woman Abuse is the Presenting Problem

Major Point #4: There are several elements that we know about violent families which can help us when we are working with children.

What do we know about families in which woman abuse is the presenting problem?

- **Survival** within the system becomes the primary, overriding concern.
- **Fear** plays a dominant role in the family system. Actions occur to avoid violence or to get it over with. In most cases, there is a honeymoon phase between abuses.
- Verbal communication as a method of negotiating within the family becomes meaningless. The primary method of determining rules, what happens, etc. is **physical**—often violent.
- The family system usually forms antagonistic **alliances** in which the mother and some or all kids are pitted against the father (and maybe one of the kids).
- There are often two different and non-complimentary sets of rules functioning within the family system. The dominant rule system is the father's. He usually has a great deal of power and sets these himself. The other rules in the system are mothers'. These rules tend to govern her relationship with the kids and the kids relationships with each other when father is not around.
- The family rules don't make sense to the outside world or family members' concepts of what a family should be. This leads to increasing **isolation** of family unit, increasing closedness of system, solidifying of patterns, homeostasis.

- Verbal **communication** and physical interchange are **inconsistent** in families. Often double binding messages are a large part of communication.
- Everybody is **hurting** or develops methods to not feel. Family members become isolated from each other, yet enmeshed.
- The abuse gets **worse** over time. The rules of the system are a game without end.
- Most family members go through periods of feeling and acting **crazy.**
- All families have certain levels of **denial** about the abuse. Family members often have not talked with each other about the abuse.
- The **children** are always **aware** of the abuse.
- Children learn about families, rules, how to negotiate rules, how to change rules primarily from their families of origin and their society.
- Rules about how to show love are entangled with violence.
- Intimacy in the family system is physical—both violent and sexual.
- Children from homes where woman abuse occurs often display acting out or withdrawal behaviors—generally exhibited along sex role lines.
- In families where woman abuse occurs, parenting becomes coping. Often parenting is a secondary issue for women, becoming important 3 to 6 months after they have left the abusive situation.
- There is often a parental child.
- Generally, men who abuse women don't go for counseling.

VI. Programs for Children

Major Point #5: Working with children means working with the child's family system. The first step in working with the family system is to have the whole family participate in an assessment of their own system.

Go through the Family Interview with the participants asking for comments and questions. Another assessment tool for children is drawing. You can ask the child to draw a picture of him/herself and/or of his/her family, then ask questions about the pictures. Often children feel more comfortable talking about their pictures rather than talking about themselves and their families in real life. See Assessment Tools in Appendix D.

Another form of assessing children is to simply interview them. (See Appendix D.) Begin by explaining to the child why you are asking the questions. This may be the first time the family secret about the violence has been verbalized. So that the child won't feel he/she is betraying the family by discussing the violence, bring the violence up first with the whole family (or as much of the family as you are seeing) together. This will legitimize that it is OK to talk about the violence now.

Go over the possible intake questions with the participants.

Major Point #6: Working with groups of children is an effective way to modeling verbal negotiation and teaching social and relationship skills, as well as empowering children as a group.

Three groups are used by DCABW for working with children: **Kids' Workshops, Kids' Meetings, and Family Meetings.** Each of these have some different emphases. These workshops and meetings were designed for a shelter setting, however, some of the elements can be used in other situations.

Kids' Workshops

Kids' Workshops are regularly scheduled times, when children living in the shelter, some children who were recent past residents, and two adult workshop facilitators participate in therapeutic play.

The power of play is extraordinary and supremely serious. It is the most natural way for a child to use his/her capacities, to grow, and to lern many skills.[1] The therapeutic aspects of play as used in the Kids' Workshops focus on expressing, exploring and integrating the experiences of violence a child has had in his/her home.

Purpose of Kids' Workshops:

1. To provide the children with the opportunity to explore and express their feelings through play.
2. To model and teach children alternative ways of dealing with and expressing these feelings.
3. To provide the children with an adult-guided chance to play with each other.

4. To provide the children with the experience and model of two adults, co-facilitators, working together cooperatively.
5. To provide children with a creative channeling of their energies through drawing, sculpting, painting, acting, puppeteering, cooking, dancing, singing, playing music.
6. To break the weightiness of the environment of the shelter which houses families who are in crisis.
7. To provide the experience of and model non-competitive play and interaction for/with the children.
8. To model and give the children an opportunity to practice cooperative activity together.
9. To model and practice the use of verbal negotiation, sharing materials for projects and/or doing collective projects.
10. To validate what kids do and say.
11. To provide opportunity for non-verbal expression of creativity and feeling.

Methods

1. Kids' Workshops are held on Monday and Thursday nights at 7:00 pm at the same time mothers are in either parenting or human relations workshops.
2. Facilitators coordinate Kids' Workshop projects with mother workshop projects.
3. Kids are split up into age groups for the workshop.
4. Workshop activities include: a) drawing a life size picture of oneself and talking about what one does and does not like about that self, b) acting out in pantomime the emotions of happy, mad, sad, and discussing and acting out other ways of expressing those emotions, c) playing how to ask for what you want game, d) doing values clarification exercise.
5. Kids regroup for a treat at the end of the workshop.
6. Facilitators are available for consultation with mothers after the workshop.

Role Play

If you have time, have participants break into groups of 5 or 6 and role play a Kids' Workshop. One or two person(s) will be facilitator(s). Assign one person to play a withdrawn child, one an aggressive child, one an overachieving (super good) child. Have the children act out and talk about the feelings—happy, sad, and mad. Talk about how the role play went afterwards.

Kids' Meetings

Kids' Meetings are regularly scheduled times when all of the children living at the shelter and a staff group facilitator meet to talk, to play, to work out how they are living together.

Purpose:

1. To provide the shelter staff with an opportunity to recognize and connect with the children in the shelter as a group.
2. To provide the children at the shelter with an opportunity to recognize and connect with themselves as a group.
3. To develop with the children at the shelter a positive peer support group during a time of crisis and transition in their lives.
4. To provide the children at the shelter as a group with an opportunity to talk about and express their experiences and feelings toward the violence they encountered in their families.
5. To provide the children at the shelter with an opportunity to negotiate aspects of their living situation with each other and an adult.
6. To model and provide children with an opportunity to develop and practice verbal negotiation as a means of communicating their needs, feelings, experiences, or wants with peers and/or siblings in the shelter.
7. To model and provide children with an opportunity to develop and practice listening skills.
8. To validate the feelings and problems which children are having while at the shelter.
9. To provide the shelter staff with an opportunity to assess the child(ren)'s peer relationships.
10. Empowerment.

Method:

1. Kids' Meetings are held three times a week on Monday, Thursday, and Friday.
2. Shelter staff is responsible for the organization and participation in Kids' Meetings.
3. Kids' Meeting is usually held before dinner in the kids' room.
4. Kids' Meetings begin with a short group activity designed to bring individual members together. (The age range of kids in the meetings has been from infant to 15). Depending on the composition of the group it may break up into smaller groups. Warm up group activities have included playing musical instruments, dancing, rubbing backs.

5. Focus on a topic area such as: a) Why are you at the shelter? b) Rules for co-existing while at the shelter. c) What's my family like for me? d) How I feel and what I do when Mom and Dad fight?
6. Kids' Meetings end with a wrap up session which may focus on a group activity, individual's plans for the next day, or saying farewell to a family that is leaving the shelter.

Family Meetings

The idea behind family meetings is to facilitate the family's talking about themselves with each other. The advocate is there to teach the family how to do this. The family meetings should be facilitated less by the advocate and more by the mothers as they progress.

Purpose:

1. To develop verbal communication skills in the family.
2. To facilitate the family's discussion on the violence they experienced.
3. To facilitate the family's discussion of what change they may want in their structure or functioning.
4. To teach and practice new ways for family members to relate to each other according to the desired change they decide upon.
5. Empowerment.

Methods:

1. Meetings are decided upon at assessment by mother and advocate.
2. Behavioral contracting
3. Role playing
4. Modeling
5. Creation of family sculptures
6. Structural reorganization

Major Point #7: Another effective way to facilitate change in children's behavior is to work with the parents on restructuring their interchange with the child.

Two groups that are used at DCABW for the mothers are the **Parenting Workshop** and the **Human Relations Workshop.**

Parenting Workshop

Parenting Workshops are regularly scheduled meetings when mothers living at the shelter, some mothers who are recent past residents, and two workshop facilitators participate in discussion and problem solving about parenting and the particular difficulties confronting women and their children who have recently come to the shelter from a violent home situation.

The concept of parenting is approached from the perspective of economic, social, sexual, familiar realities of parenting in the present day culture. Questions are posed about 1) economic role of motherhood, 2) the mother-child relationship as a learning interchange, 3) approaches to parenting, 4) particular behavioral problems mothers have with their children, and 5) the effects of a violent family system on its members.

The Parenting Workshop is particularly designed for women-mothers who are at the shelter because of violent disruptions between themselves and their partners. The material reality of parenting for these women while at the shelter has been examined and incorporated into the design of the workshop. Following are some of the things we know about these family systems:

1. Women and their children at the shelter come from violent homes. It is likely that their family systems have incorporated the violence into the rules of how they relate.
2. At the point in her life when a woman comes to the shelter, her primary concern is not likely to be parenting. Both the woman and her family are in a state of crisis. She is dealing with making a decision about her relationship with her partner, about where to live and how to support her family. She may be apartment hunting, dealing with lawyers, looking for a job. And then there are the kids. These mothers are not likely to have time or energy to even cope with the children much less be creative.
3. Some of the women who come from partner abuse situations have learned through the violence perpetrated against them to be very passive. For them, taking charge of the family may necessitate learning or relearning new behavior patterns. This takes time, energy, and encouragement.
4. Children coming from violent home situations are likely to display 1) aggressive acting out behavior, 2) withdrawal, or 3) model behavior. He/she needs special attention and the experience of new ways of being, to help

him/her change these behaviors. Without support, the mother is not likely to be in a place to provide this special attention while at the shelter. Even with support, the family may have more primary issues to pursue.

5. While at the shelter, a mother and her child(ren) live with up to 15 other women and children. This is not a family's usual situation. It is difficult to know how a strange house, strange people, and sharing space, energy and time affects individual family members or the family system.
6. Women who come from violent partner situations have often become isolated from family, friends, community. They usually have had concentrated energy to keep the family secret: "He beats me." Talking about the family to others may have been taboo. Talking about parenting is already uncomfortable for most women because of the role of "mother" in the society (who is supposed to be good, patient, understanding, etc., etc.)—for battered women it may be even more difficult.
7. Women are at the shelter for a short period of their mothering career.

Purpose:

1. To provide each participant with an opportunity to discuss parenting in general, her parenting specifically.
2. To provide a safe, supportive atmosphere for the discussion of parenting.
3. To provide participants with an ongoing support group around the issue of parenting.
4. To provide participants with a structured opportunity to connect as mothers, single parents, women from abusive relationships, adults sharing some parenting with each other.
5. To teach, model, practice, and evaluate the problem-solving method of dealing with parenting.
6. To help each woman clarify what she wants of her relationship with her children.
7. To help each woman figure out how to achieve the relationship she wants with her children or to change her expectations.
8. To provide a perspective of parenting as a learned skill, not an intuitive one.
9. To teach specific parenting skills. Provide an opportunity for discussion, role rehearsals, evaluation and check back.
10. To provide a perspective of the family as a system.
11. To validate the struggles women face and experience as parents.
12. To model and practice verbal negotiation about parenting between adults, the workshop participants, who are at the shelter living together.
13. To discuss, practice and evaluate mothers taking charge of and directing change in the family system.
14. To provide an opportunity for participants to learn, practice and utilize relaxation techniques.
15. Empowerment.

Methods:

1. Parenting Workshops occur weekly.
2. Past and present residents of the shelter are welcome to attend.
3. Facilitators meet and coordinate workshop with Kids' Workshop facilitators.
4. Workshop begins with a check-in. Each woman is asked how she is feeling as a mother.
5. Topic for the week is discussed or presented. (Topic is decided by women at the previous week's meeting.) Topic areas include a) the family in a state of crisis, b) how to say no effectively, c) consistency, d) how learning occurs, e) being a single parent.
6. Some Parenting Workshops end with a relaxation exercise.

Human Relations Workshop*

The Human Relations Workshop was designed to help the women explore the many aspects of their relationships in general, as well as with the abuser. Through discussions, the sharing of ideas and feelings, and providing information the participants are able to become aware of and understand their interpersonal interactions. Throughout the workshops several facets are stressed: roles, communications, rules and behaviors. These workshops are particularly good for battered women in that they can examine the influences on their relationships and patterns they may have. Since the women are either trying to make changes or leave their situations, it becomes necessary for them to become cognizant of the processes of forming relationships and ways changes can be made. The women examine their values, attitudes and feelings both about their present relationship and about possible alternatives.

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*This workshop description was written by Linda Szczepkowski, Family Advocate, Dane County Advocates for Battered Women, Madison, Wisconsin.

The goals of the workshops are to increase their empowerment, self-determination, and control in their relationships. We hope to develop feelings of independence, teach new skills, and to reverse the learned helplessness process. The groups are a medium for helping the women work through problems and enhance personal growth.

The perspectives of the workshops are that battered women are not "masochistic," nor are they "sick" in need of a "cure." The women do not provoke the violence, nor do they have to accept it; rather, they are part of a system that has produced the violence. It is important that she look at her role within that system, her behaviors and communications. The women are not encouraged to leave, but are given support around changes they determine to make.

The groups are also valuable for battered women because they are usually isolated from others. Through the sharing of feelings and ideas the women can gain support from their peers and become more aware of themselves in an open, sympathetic environment. If the women are to free themselves from abusive relationships, and (re)gain internal strength, they need to understand how they function interpersonally, their prejudices, and their own sexism. Although particular workshops may have sub-objectives, the general purpose of all is to enhance self-exploration and self-awareness. The participants consist of two co-facilitators and the women; no observers are allowed unless permission by the women has been given. Everything that takes place and is said is confidential.

Purpose:

1. To provide past and present residents of the shelter with the opportunity to discuss and share how they relate to the world as mothers, wives, single parents, women, and sexual beings.
2. To provide an opportunity for participants to learn and practice problem-solving skills.
3. To provide participants an opportunity to learn and practice assertiveness skills.
4. To enhance women's awareness of how she is feeling in the here and now.

Methods:

1. Human Relations Workshops occur weekly.
2. Past and present residents of the shelter are welcome to attend.
3. Facilitators meet and coordinate the workshop with the Kids' Workshop facilitators.
4. The workshop begins with a check-in. Each woman is asked to focus on one of her relationships with her world.
5. Topic for the week is discussed or presented. Topic areas include: a) human sexuality, b) female role in the family, c) family life planning, d) problem-solving techniques, e) assertiveness training.
6. Most human relations workshops end with a relaxation exericse.

VII. Evaluations

Session 8
Child Abuse/Neglect and Incest*

Purpose

To introduce the topics of child abuse/neglect and incest, define the scope of these problems, and give counselors some beginning ideas for assessment and intervention.

Agenda

- I. Check-in and Review of Homework
- II. Introduction
  - A. Incidence of child abuse/neglect
    - Overlap with AODA
  - B. Incidence of incest
    - Overlap with AODA
  - C. Short history
- III. Community Treatment Approach
  - A. Law enforcement
  - B. Social services/child protection
  - C. Treatment
    - 1. Self-help groups
    - 2. Individuals—couples—family
- IV. Family Dynamics
- V. Break
- VI. Film
  - A. Introduction
  - B. Film showing
  - C. Discussion
- VII. Treatment Indicators for Counselors
- VIII. Evaluations

Objectives

At the end of this session, participants will be able to:

1. Relate at least two statistics on the extent of child abuse/neglect and/or incest.
2. List at least four kinds of treatment useful for families experiencing child abuse and/or incest.
3. List at least 3 common characteristics of sexual abusers.
4. List at least 4 fears sexually abused child may have.
5. List at least 3 common characteristics of families in which child abuse occurs.
6. Identify at least four steps for counselors to take when working with a child abusing family.

Notes to the Instructor

Necessary Equipment	Projector Film Screen
Handouts	#10 in Appendix /D
Homework	None

I. Check-in

II. Introduction

Major Point #1: Child abuse and neglect is an extensive problem in this country. One estimate is that there are about 1 million cases per year.[1]

- Of the 1 million cases of child abuse per year, about 2,000 children die—that means one child dies every four hours.[2]
- Child abuse/neglect occurs in every segment of society: rich and poor, educated and uneducated, cities, small towns and rural areas, all races.

Major Point #2: Child sexual abuse is a much greater problem than it was once believed to be, involving 200,000-500,000 children a year according to some authorities.[3]

- One out of four children will experience some form of inappropriate sexual behavior, ranging from actual intercourse to indecent exposure.[4]

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*This session was originally planned and presented by Elthea Steidemann and Sharon Hanson of the Parental Stress Center, 1506 Madison St., Madison, Wisconsin.

- In 80-90% of cases of child sexual abuse, the offender is known by the child or other family members. The offender is frequently a family member.[5]

Major Point #3: Alcohol and other drug abuse appears to be an overlapping problem in a substantial number of families where child abuse/neglect and/or incest is occurring.

- Several studies have documented that parents with alcohol problems have a high potential for exhibiting neglect of their children, especially through erratic and inconsistent parenting.[6]
- Dr. Henry Kempe states that alcohol plays a part in approximately one-third of child abuse cases.[7]
- Alcohol may play a significant role in many sex offenses against children. Some studies show that as many as a quarter of the offenders have a history of an excessive use of alcohol.[8]
- In the Madison Parental Stress Adult Oasis Group (for incest victims), 66% of the participants had some chemical dependency problem in their families.

Major Point #4: Child abuse/neglect and child sexual abuse are not new problems.

Since ancient times, incest has been prohibited in most societies. The taboo was originally enforced by the tribe and later by the church. Today it is enforced through the courts as well.[9]

Physical punishment is generally approved of even today as a method of disciplining children and the Supreme Court has sanctioned its use in schools.[10] Physical punishment of children by the parents has been seen not only as the parents' right but also as their responsibility!

III. Community Treatment Approach

Major Point #5: The problems of child abuse/neglect and child sexual abuse require a comprehensive approach to prevention and treatment.

Child abuse/neglect and child sexual abuse almost always necessitate the involvement of the law enforcement system, social services (particularly the child protection unit) and community treatment programs. Wisconsin has a mandatory reporting law. If a counselor suspects possible abuse or neglect, he/she must call the child protection unit to report. The child protection unit will then visit the family in an attempt to substantiate the report. Law enforcement may become involved if charges are pressed against the abuser. Often treatment will be required in lieu of incarceration or other penalties.

There are many different kinds of treatment being used across the United States. There are self-help groups for the abusers (such as Parents Anonymous). Self-help groups for former victims of incest are becoming increasingly common. Most families will also be encouraged (or required if the courts are involved) to seek family, couple, and/or individual counselling. The Family Renewal Center in Minneapolis, MN. sees the whole family in therapy, as well as peer groups, family groups, educational groups and self-help groups in an intensive program for families in which child sexual abuse is occurring. Their self-help groups for abusers, victims, and other family members use the same 12 steps as AA and Al-Anon, adapted for sexual abuse. The program is based primarily on the addiction theory, underscoring that sexual abuse is an addictive behavior that can be stopped.[11]

Henry Giarretto, Director of the Child Sexual Abuse Treatment Program, Santa Clara County Juvenile Probation Department, San Jose, CA. has found that family therapy is less effective in the early stages of treatment. His treatment program occurs in the following order:

1. a. Individual peer support immediately for child, mother, father.

   b. Individual counseling for child, mother, father. — These are concurrent and simultaneous
   c. Group counseling.
2. Mother-daughter counseling.
3. Marital counseling.
4. Father-daughter counseling.
5. Family counseling.[12]

He also believes that the involvement of the criminal justice system is at times a necessary prelude to treatment: "In all cases the authority of the criminal justice system and the court process the offender must undergo seems absolutely necessary in order to satisfy what may be termed an expiatory factor in the treatment of the offender and his family. It appears that the offender needs to know unequivocally that the community will not condone his incestuous behavior and that it will exact a punishment. Victims and their mothers have also admitted to deriving comfort from knowledge of the community's clear stand on incest. All family members, however, will do their best to frustrate the system if they anticipate that the punishment will be so severe that the family will be destroyed and that they, in turn will become 'victims' of the criminal justice system."[13]

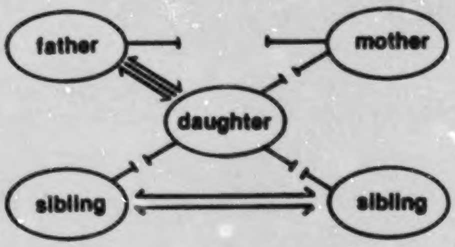
The cooperation of the community resources will lead to a more effective, comprehensive plan for helping abusive families.

IV. Family Dynamics

Major Point #6: While we cannot stereotype abusive families, there are some commonalities which can be useful for counselors for assessment and treatment indicators.

Sexually Abusive Families

Incestuous Families: Lines of Communications



Characteristics of sexual abusers:

1. Was severely emotionally abused as a child/ may have been physically abused/may have been sexually abused.
2. Low self-esteem.
3. Isolated.

The sexually abusing father turns to a daughter for emotional support. Their relationship may seem pretty good for a while. But at some point, the father crosses a line and the special father/daughter relationship becomes sexual.

Daughter is generally pleased with the special relationship in the beginning, enjoys the attention. She finds that her nurturance of her father pleases him so she increases it. Then, after their relationship becomes sexual, the daughter begins to feel uncomfortable and may resist. At this point, the relationship often becomes coercive. The daughter is warned that bad things could happen if she talks about the sexual nature of this special relationship:

1. Mother may be very angry/hurt/go crazy.
2. Father may be put in jail.
3. Daughter may be blamed for breaking up the family.
4. Daughter may be taken out of the family.
5. Daughter may not be believed.

The daughter may also be feeling guilty. She may have enjoyed some of the sexual activity with her father. She may feel she allowed the sexual activity to occur—that she should have found *some* way to stop it. She often still has the feelings of love and concern for her father—these can be confusing when mixed with feelings of anger and betrayal. All of this contributes to the daughter's low self-esteem. The daughter may have difficulty separating affection from sexuality, which causes more and more problems as she matures.

The mother in an incestuous family has often been berated in literature as the cause of the problem.[14] However, she cannot be held responsible for the man's behavior. She is generally feeling dissatisfaction in the marriage. She is aware of a distance between her and her daughter but may not understand it. In fact, the mother-daughter relationship may be the most damaged in the incestuous family.[15]

The siblings are also affected. The father may also be molesting one or more of them. If not, they are aware of a special relationship between their father and this one daughter. Boys who are aware of the incest may also begin molesting this sister.

Child Abuse/Neglect Families

Sinetta and Rigler's findings report low frustration tolerance, low self-esteem, impulsivity, dependency, immaturity, severe depression, problems with role reversals, difficulty in experiencing pleasure, and lack of understanding the needs and abilities of children as characteristics of the child abusing family.[16]

Child abuse may occur under a variety of circumstances. The parents may have lost control of the child(ren) and be able to enforce their wishes only through abuse. One child may have been selected out as particularly "bad" — perhaps because he/she is different in some way (small, sickly, retarded, unattractive, etc.), or because he/she looks like or reminds the parent of someone they don't like, or the child is considered shy or weak, or aggressive or disobedient, or the child is unwanted. In some cases, children who try to intervene in the violent episodes between their parents are battered. Or, the woman who is being battered by her partner, may take out her frustrations on her child(ren). Some of the characteristic behaviors of children who experience family violence are:

*1. Role reversal — often one child may assume some or most of the parental responsibilities.
2. Aggressive behavior.
3. Violence towards parent(s).
*4. Running away.
*5. Truancy.
*6. Shy, withdrawn behavior.
*7. Substance abuse.
*8. Abusive behavior as adults.[17]
*9. Precocious sexual behavior.
*10. Sudden change in school performance.
*11. Personal boundaries very unclear, indefinite, e.g. inappropriate sharing of personal information.

V. Break

VI. Film (See list of recommended films, Appendix C)

Discussion Questions — general:

1. How were you affected by this film?
2. Are there any questions?
3. Did you disagree with something?
4. Write down one new thing you learned from this film.

VII. Treatment Indications

Major Point #7: A counselor working with a child abusing family can follow certain steps in assuring effective treatment.

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1. Safety for each family member is the top priority. In sexual abuse cases, the abuser is generally asked to leave the home for a period of time. In child abuse, the batterer may be allowed to remain in the home if the child's physical safety can be reasonably assured.
2. If there is an AODA problem, treatment for this must begin immediately.
3. Individual counseling and counseling the family dyads (partner/partner, abuser/abused child, non-abusve adult/abused child) should begin shortly after the AODA counseling is begun.
4. Family counseling is important after the other counseling has been ongoing.
5. Peer, self-help groups have been proven helpful from the beginning and as ongoing support.
6. Before working with child abusing families, counselors must confront their own attitudes and feelings about child abuse and child sexual abuse.

VII. Evaluations

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*Often characteristic of child in sexual abuse.

Child Abuse/Neglect and Incest
Footnotes and References

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[3] From *Public Concern and Personal Action: Child Sexual Abuse,* Child Protection Center—Special Unit, Children's Hospital National Medical Center, Washington, D.C., 1980.

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[5] Ibid., p. 4.

[6] Cork, M. R. *The Forgotten Children.* (Toronto: Paperjacks, in association with Addiction Research Foundation), 1969; Fox, R. "Treating the Alcoholics Family" in Catangaro, R. J. (ed.), *Alcoholism* (Springfield, Ill.: Charles C. Thomas), 1968. pp. 105-115.

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[8] Swanson, D. W. "Adult Sexual Abuse of Children (the Man and Circumstances)" in *Diseases of the Nervous System,* 29:677-83, 1968.

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[10] Steinmetz, Suzanne K. and Straus, Murray A., "General Introduction: Social Myth and Social System in the Study of Intra-Family Violence," in Steinmetz, Suzanne K. and Straus, Murray A., *Violence in the Family* (New York: Harper and Row), 1974. p. 3.

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[12] Giarretto, Henry, "The Treatment of Father Daughter Incest: A Psycho-Social Approach." *Children Today,* July-August, 1976. p. 3.

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[14] Giarretto, Henry, "Humanistic Treatment of Father Daughter Incest." *Journal of Humanistic Psychology,* Vol. 18, No. 4, Fall, 1978. p. 62.

[15] Stern, Maddi-Jane and Meyer, Linda C. "Family and Couple Interactional Patterns in Cases of Father/Daughter Incest," in Jones, Jenstron, MacFarlane (eds.), *Sexual Abuse of Children: Selected Readings,* National Center on Child Abuse and Neglect, Children's Bureau, Administration for Children, Youth, and Families, Office of Human Development Services, U.S. Department of Health and Human Services, DHHS Publication No. (OHDS) 78-30161, November, 1980. p. 84.

[16] Spinetta, J. J. and Regler, D. "The Child Abusing Parent. A Psychological Review." PB 4, 296-304, 1972.

[17] Barnett, Pittman, Ragan, Salus, *Family Violence: Intervention Strategies,* U.S. Department of Health and Human Services, Office of Human Development Services, Administration for Children, Youth and Families, Children's Bureau, National Center on Child Abuse and Neglect, DHHS PUblication No. (OHDS) 80-30258, May, 1980. p. 28.

Session 9
Wrap Up/Staff to Staff Workshop

Purpose

To provide an opportunity for the staffs of the two agencies involved in the cross-training to get together, meet one another, discuss common concerns, and share their separate referral policies. This meeting will also encourage cooperation between the two staff groups.

Agenda

- I. Introductions of All Present
  - A. Each person spends 1-2 minutes explaining his/her job
- II. Case Histories (Break into groups of 5-6)
  - A. Each person writes and shares a case with the group that involves an AODA related violent family.
    - 1. Discussion of each ase
- III. Referral Procedures
  - A. Each staff shares their referral procedures with the other staff
    - 1. Questions and discussion
- IV. Break
- V. Brainstorming: How Can Our Two Staffs Cooperate?
- VI. Wrap-up
  - A. Thank yous and good-byes
  - B. Evaluations

Objectives

At the end of this session, participants will be able to:

1. Give brief job descriptions for at least half of the staff from the other agency.
2. Identify by name all of the other participants in this workshop.
3. List the necessary referral procedures for the other agency.
4. List at least three ways that the two staffs can cooperate.

Notes to Instructor

Necessary Equipment: Chalkboard or flipchart.

Ideas:

1. Have one person from each staff share their respective referral procedures.
2. Take a long break (15 minutes) so that people have a chance to mingle.
3. After the session, type up the ideas that come out of the brainstorming session and send copies to all participants.
4. In the evaluation, ask participants to write down what they feel was the most valuable part of the training.

CONGRATULATIONS!
You have completed the training program.

Chapter III

Sessions on Chemical Dependency

Getting Ready to Go

Since most communities do have services for alcoholics and other drug abusers, this chapter assumes the trainer will have some expertise in this area. Therefore, the sessions are outlined but not as fully described as the sessions on family violence. There are also some excellent training materials available on alcohol and other drug abuse.

The sessions outlined here were developed for use specifically with advocates working with shelters and other programs for battered women. These sessions can be adapted for the staffs of other helping agencies.

In this chapter there are outlined eight 1½-2 hour sessions. Two additional sessions for this training can be taken from the sessions on Woman Abuse: "The Connection Between AODA and Family Violence" and "Wrap Up/Staff to Staff Workshop." Each session is arranged in the following format:

First the major purpose of the session is described. Then comes the agenda for that session on the same page. This page can be copied and distributed to participants at the beginning of each session.

The next page outlines what each participant should learn by the end of the session and also contains particular instructions for that session for the trainer.

The session is next outlined with the major points boxed for emphasis and including other supporting information. Each session description concludes with footnotes and references.

The sessions for this training, then, are as follows:

1. **Introduction to Chemical Dependency.**
2. **Introduction to Other Drug Abuse.**
3. **Assessment and Intervention Techniques.**
4. **The Family Illness.**
5. **The Connection Between Chemical Dependency and Family Violence.**
6. **Working with Children from Chemically Dependent Families.**
7. **Working with the Woman Chemical Abuser.**
8. **Fetal Alcohol Syndrome and Other Effects of Chemicals on Pregnancy.**
9. **Group Approach to Chemical Dependency.**
10. **Wrap Up/Staff to Staff Workshop (see Session #9 in Woman Abuse Section).**

Session 1
Introduction to Chemical Dependency*

Purpose

To introduce the participants to some basic information on alcohol: its extent, definitions, and the progression process.

Agenda

- I. Introductions
    - A. Introducing yourself and participants
    - B. Sharing an outline of the training program
    - C. Questions, suggestions and expectations
    - D. Discussion of basic rules
        1. Smoking
        2. Breaks
        3. Beginning and ending time
    - E. Discussion of evaluation process for program
- II. Pre-test and Questions
- III. Chemical Dependency
    - A. Definition
    - B. Physical effects of chemical dependency and abuse
    - C. Why people use
- IV. Progression of Chemical Dependency
- V. Break
- VI. Early Recognition of Chemical Dependency
- VII. Film
    - A. Introduction
    - B. Film showing
    - C. Discussion and questions
- VIII. Evaluations

Objectives

By the end of this session, participants will be able to:

1. Define alcoholic.
2. Quote at least one statistic on the extent of the alcohol abuse problem.
3. List at least four physical effects of alcohol.
4. Draw charts showing the four stages of drinking; social drinker, beginning abuser, abuser, and chronic; and their states in the pain, normal, euphoria continuum when drinking.
5. List at least five warning symptoms of a possible alcohol problem.
6. Identify at least six points along the progression chart.

Notes to the Instructor:

Necessary Equipment:	Film Projector Screen Handout #A Evaluations Chalkboard or flipchart
Homework:	Assign each participant a newspaper or magazine to check during this entire training program. Have them clip out any references in news, advertising, comics, stories or editorials to alcohol or other drugs. Ask them to keep a scrapbook of these clippings to share with the group at a later date. Also have each person contract to abstrain for 15 days from a mood-altering chemical of their choice, or from all chemicals. Examples: sugar, caffeine, nicotine, alcohol, etc. In session #3, the assignment will be discussed.

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*This session was originally planned and presented by Kathleen Bartell, CADC, SCHARE Out-Patient Department, Stoughton Hospital, Stoughton, Wisconsin 53589.

I. Introduction

II. Pre-test and Questions

III. Chemical Dependency

Major Point #1: Chemical dependency is a pathological relationship of a person to a chemical in expectation of a rewarding experience. A chemically dependent person is someone whose drinking/drug use causes problems in any area of his/her life, i.e., health, family, social, spiritual, emotional, mental, legal, job; and he/she continues to use.

There has been much confusion around the terms "alcoholic," "alcohol/drug abuser," "addict." The debate over how physically dependent a person must be to be chemically dependent continues. However, the above definition is fairly widely accepted and will be used for the purposes of this training.

Major Point #2: Alcoholism/Chemical Dependency is a major health problem. Our country has not only a drug problem, but a "drug problem" problem—the damage that results from the ways in which society has approached the drug problem.

When we look at drug use in America today, we discover that our entire society is very drug-oriented. Almost every person in the United States uses one or more drugs regularly. Over the past few years, Americans have spent more than $30 billion annually for legal drugs that change awareness and mood.[1] The use of illegal drugs for those same purposes is still increasing among all parts of American society.

Alcohol is the most widely used drug in the world—approximately 80 million Americans from all social and economic groups use alcohol. Alcohol misuse also presents the greatest drug problem in the United States today. There are between 10 million – 17 million problem drinkers.[2] It is very difficult to obtain complete, accurate statistics on the number of people in this country who use illegal drugs. Social disapproval often keeps people from admitting the extent of their drug use, as does the fear of getting involved with the law. Some estimates:

- Marijuana users—24 million (The President's National Commission on Marijuana and Drug Abuse, 1972).
- Prescription CNS depressant drugs—20-25 million (used to be mostly older people but generation gap has closed).

There are several ways in which the "drug problem" relates to our society. We use drugs for many reasons, often as solutions to problems. Also, there are an overwhelming number of psychoactive (mood-altering) drugs that are available, both legally and illegally, in the United States today. Hundreds of new drugs have been discovered, invented, tested and heavily advertised since 1950.[3]

Another way the "drug problem" relates to our society concerns American attitudes about drugs. Although the abuse of many drugs has grown tremendously since the 1950's, our society has focused its concern mainly upon the use of a few specific drugs by certain kinds of people. Mistakes in drug laws, policies, and attitudes are thoroughly discussed and documented throughout *Licit and Illicit Drugs*.[4]

Finally, in understanding the "drug problem," recognition needs to be made that, just as people use/abuse drugs for many reasons, the decisions to use or abuse drugs is made by each person alone. It is just one of many decisions that are made in the cause of everyday living and planning for the future.[5]

IV. Progression of Chemical Dependency

Major Point #3: People use alcohol and other mood-altering chemicals in the beginning because it makes them feel good, euphoric. However, dependents eventually use to feel normal and finally to forget their misery or because they are compelled.

Alcoholism/Chemical Dependency can be looked at as disease. A disease has its own symptoms and is describable, such as diabetes. It is a:

A. **Primary Disease.** It is not a secondary symptom of something else.

B. **Progressive Disease.** It gets progressively worse. The individual becomes physically, mentally, spiritually and emotionally ill.

C. **Chronic Disease.** There is no cure. Relapsing is common. There is no way to drink or use again.

D. **Fatal Disease.** The disease can only be arrested. If it is not arrested, the person will die from it.

Through much applied research, a way of looking at this disease (dis-ease)has been developed which suggests that this condition can be accurately described in terms of a special kind of emotional distress.[6] In order to illustrate this universal emotional pattern of chemical dependency, a Feeling Chart is used. This is essentially a straight line graph where all human emotions can be represented. The mood swings, which are the emotional symptoms of chemical dependency, are shown on successive graphs as the inevitable deterioration of the self-image of the suffering chemically dependent person.

The Feeling Chart

Normal

Pain Euphoria

Human feelings are registered graphically from left to right. The feelings can range from suicidal despair to ecstasy. Theoretically, everybody is somewhere on this graph at any given moment.

Progression of the Disease

I. **Phase 1 – Learns Mood Swing.** On the feeling chart, use starts at the normal position and moves toward euphoria and always returns to the normal position.

Pain Normal

Euphoria

1. Person can control the degree of the mood swing.
2. Individual learns it works every time. This is learned experientially – the most powerful method of learning.
3. It becomoes a basic trust relationship. It is a welcome direction.
4. Person uses chemical to establish relationships with others – a friend is found in the chemical.

II. **Phase 2 – Seeks Mood Swing.** On the feeling, chart use starts at the normal position and moves toward euphoria and returns to normal, sometimes moves into the painful area.

Pain Normal Euphoria

1. Can control use – behavior is still appropriate.
2. Becomes mildly habituated.
3. Pays little or no emotional or physical cost at this stage – a few first hangovers – some physical discomfort, but in comparison to the "high," *it was worth it!*
4. If some situation would arise at this stage where alcohol/other drug could not be reached, the individual would not be too upset.
5. This pattern becomes well worn – there are many, many drinkers and chemical users at this stage.

III. **Phase 3 – Harmful Dependency.** On the feeling chart, use begins to start in the painful area and it takes increasing amounts to get to the euphoria area. An emotional price is paid for the behavior which accompanies the chemical use.

Pain Normal Euphoria

1. Changes life-style and behavior patterns. Breaks own value system. Begins to arrange life around chemical and expects others to do the same.
2. Anticipation and preoccupation with the use of the chemical grows.
3. Tolerance to chemical grows – takes more and more to get same effect – and in the case of barbiturates with the lethal dose remaining the same, overdose is relatively easy. In heroin addiction, the tolerance is constantly growing – with plateaus.
4. Ingenuity in getting, drinking, keeping chemical grows. Doesn't get too far from supply.
5. Rigidity around the times and places of use increases. Becomes intolerant of situations and people.
6. Rationalizations. Blaming, excuses, alibis begin. Wall of defenses is being built. Becomes very defensive about use.
7. Projection begins. As self-hatred grows, projection grows. As projection grows, family defenses grow, family denial grows.
8. Blackouts (loss of memory while under the influence) begins to occur.
9. Delusion begins. The individual doesn't believe s/he is in trouble; however, fears are growing. Anxiety, guilt and remorse grows. The person becomes a victim of his/her own defense system, unable to see his/her behavior. The *core* of the disease is this total denial and/or delusion.

10. The disease progresses. Everything is going downhill. Relationships, health, social life, efficiency, spirituality, financial matters, mental and emotional stability. Growth in all areas ceases.

IV. **Phase 4 – Impaired Judgement.** On the Feeling Chart, use of chemical begins to start in the painful area and moves only to the normal position.

Pain Normal Euphoria

1. All feelings and symptoms of Phase 3 are heightened.
2. Uses to feel normal. Tries in vain to recapture old highs but also to ward off withdrawal pain.
3. Many physical problems. Spiritually, emotionally and psychologically sick. Impaired judgement, faulty memory.
4. Chemical use urgency is greatly increased. Desire to use chemical becomes all important, out-weighing *all* other human drives.
5. Tolerance goes down with alcohol. In such poor physical condition, the body can no longer tolerate large amounts of alcohol. The body's tolerance for alcohol will *never* return.
6. Complete loss of control. Freedom of choice is gone.
7. Paranoid thinking. High anxiety, plagued with guilt. Isolates self except for family who are usually just as sick or have "given up."
8. Self-hatred increases. All defenses in high gear. Projection increases. Often is finally left alone.
9. Fear of insanity. Feeling of total worthlessness. Extreme isolation. Feels abandoned. Spiritually bankrupt.
10. Loss of desire to live. Left alone, with no one to project miserable feelings to. May be forced to suddenly look at complete picture. Suicides often occur.
11. Death. Overdose or physical deterioration.

V. Break

VI. Early Recognition of Chemical Dependency

Major Point #4: Alcohol and other drug abusers can be identified and get help before the chronic stage or "bottoming out."

Eight common warning symptoms are:

1. Preoccupation with getting high.
2. Increased tolerance to the drug.
3. Gulping drinks, taking drugs in a manner that they will act faster.
4. Using alone.
5. Using drugs/alcohol as medicine.
6. Blackouts.
7. Protecting the supply.
8. Non-pre-meditated use of drug – using more than you had intended.

A counselor/advocate can use these symptoms with people with whom they work as initial questions. Counselor/advocates can also think about these in terms of their own drinking and/or other drug use.

VII. Film

Some questions you might ask after the film are:

1. Do you have any questions or concerns about the film?
2. What was one new thing that you learned?
3. How many of you were thinking about your own drinking habits during the film?

VIII. Evaluations

Introduction to Chemical Dependency

Footnotes and References

[1] Summers, M. J., et al., *Our Chemical Culture* (Madison, WI: STASH Press, Inc.), 1975

[2] Langone, John and Langone, Dolores de Nobrega, *Women Who Drink* (Reading, Mass.: Addison-Wesley Publishing Co.), 1980. p. iii.

[3] Summers, op cit.

[4] Brecher, E. M., *Licit and Illicit Drugs* (The Consumer Union Report), 1972.

[5] Summers, op cit.

[6] Johnson, Vernon E., I'll Quit Tomorrow (New York, N.Y.: Harper and Row Publishers, Inc.)

Session 2:
Introduction to Other Drug Abuse*

Purpose

To introduce counselors to basic information on the kinds and types of other drugs and the progression of their misuse.

Agenda

- I. Check-in and Discussion of Homework
- II. The Medical Model of Classifying
- III. The Social Control (Legal) Model of Classification
- IV. The "Street" Usage Model
- V. Depressant Drugs—Description and Effects
- VI. Stimulant Drugs—Description and Effects
- VII. Hallucinogenic Drugs—Description and Effects
- VIII. Other Drugs
- IX. Break
- X. Relationship of Other Drug Abuse to Woman Abuse
- XI. Evaluations

Objectives

By the end of this session, participants will be able to:

1. Identify at least three drugs in each of the following categories: depressants, stimulants, hallucinogens.
2. Identify the five phases along the progression towards dependence and list at least three symptoms of each stage.
3. List at least three drug abuse interventions that advocates can take with battered women.

Notes to the Instructor

Necessary Equipment:	Chalkboard or flipchart. If possible, obtain copies of *You Asked For It* for handouts. (See references at end of this session). Evaluations
Homework:	Ask participants to think of women with whom they have worked who had AODA problems themselves or in their families. They should come to the next session prepared to do role plays. Also ask them to bring their scrapbooks of clippings from newspapers and magazines in to share with the group. (See homework assignment from Session I.)

I. Check-In

II. The Medical Model

Major Point #1: Drugs are classified by the therapeutic use they are put to.

A. Sedative Hypnotics
   1. Methaqualone/Alcohol

B. Strong Analgesics
   1. Morphine/Codeine

C. Antihistamines
   1. Chlorpheniramine/Diphenhydramine

D. Anorexiants
   1. Dextroamphetamine/Phenmetrazine

E. Antihypertensives
   1. Chlorthiazide/Furosemide

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*This session was originally planned and presented by Dan Perkins of PICADA, 17 N. Webster, Madison, WI 53703 (Prevention and Intervention Center for Alcohol and Other Drug Abuse).

II. The Social Control (legal) Model

Major Point #2: Drugs are regulated into certain classifications by legislative action.

- **A. Uncontrolled Drugs**
  - 1. Caffeine/Vitamins
- **B. Controlled by Age**
  - 1. Tobacco/Alcohol
- **C. Over-the-Counter Drugs**
  - 1. Aspirin/Ephedrine
- **D. Prescription Drugs**
  - 1.Non-controlled Substances
    - a. Ampicillin/Furosemide
  - 2. Controlled Substances
    - a. Cocaine
    - b. Heroin (Morphine)

III. "Street" Usage Model

Major Point #3: Basically drugs are valued for the type of mood-altering effect produced.

- **A. Depressant Drugs**
  - 1. Alcohol/Methaqualone
- **B. Stimulant Drugs**
  - 1. Dextroamphetamine/Cocaine
- **C. Hallucinogenic Drugs**
  - 1. LSD/MDA/Cannabis
- **D. Other Drugs**
  - 1. Nitrous Oxide Toulene

IV. Depressant Drugs

Major Point #4: All depressant drugs cause Central Nervous System (CNS) Depression.

- **A. Alcohol**
- **B. Barbiturates**
- **C. Other Sedative/Hypnotics**
  - 1. Equanil and Miltown (meprobamate)
  - 2. Placidyl (ethchlorvynol)
  - 3. Doriden (glutethimide)
  - 4. Noludar (methprylon)
  - 5. Valmid (ethinamated)
  - 6. Quaaludes (methaqualone)
- **D. Tranquilizers**
  - 1. Phenothiazines
    - a. Thorazine (chlorpromazine)
    - b. Mellaril (thioidazine)
    - c. Stelazine (trifluoperazine)
  - 2. Benzodiazapines
    - a. Valium (diazepam)
    - b. Librium (chlordiazepoxide)
    - c. Serax (oxazepam)
- **E. PCP (phencyclidine)**
- **F. Other Depressants**
  - 1. Antihistamines (Prescription and Over-the-Counter)
    - a. Chlor-trimeton (chlorpheniramine)
    - b. Phenergan (promethazine)
    - c. Dramamine (dimenhydrinate)
    - d. Benadryl (diphenhydramine)
    - *e. Pyribenzamine (tripelenuamine)
- **G. Analgesics**
  - 1. Aspirin
  - *2. Talwin (pentazocine)
  - 3. Bromides (over-the-counter)
- **H. Narcotics**
  - 1. Opium
  - 2. Heroin
  - 3. Morphine
  - 4. Codeine
  - 5. Percodan (oxycodone)
  - 6. Methadone
  - 7. Dilaudid (hydromorphone)
  - 8. Methadone
  - 9. Demerol (meperidine)
  - 10. Darvon (propxyphene)

VI. Stimulant Drugs

Major Point #5: All stimulants cause CNS stimulation.

- **A. Cocaine**
- **B. Amphetamine (speed)**
  - 1. Amphetamine (benzedrine)
  - 2. Biphetamine
  - 3. Dextroamphetamine (dexedrine)
  - 4. Methamphetamine (desoxyn)
  - 5. Chlorphentermine
- **C. Ritalin (methylphenidate)**
- **D. Preludin (phenmetriazine)**
- **E. Ephedrine**
- **F. Caffeine**
- **G. Cylert (pemoline)**

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*Taking these two together creates a "high."

H. Phentermine
Cocaine & Cut
Caffeine/ephedrine/etc.

VII. Hallucinogenic Drugs

Major Point #6: All hallucinogens cause mood-alteration and intensify sensory perceptions.

A. LSD Types
1. LSD
2. Peyote (mescaline)
3. Psilocybin
4. Morning Glories

B. MDA Types
1. MDA
2. (cannabis)
3. THC

C. Cannabis
1. Marijuana
2. Hashish
3. Hash oil
4. THC

D. PCP

VIII. Other Drugs

A. Inhalants (sniffing)—aerosol sprays from paint to gasoline
1. Cements—toulene/acetone
2. Cleaning fluids—benzene/naptha
3. Gasoline-hydrocarbons
4. Aerosols—fluorocarbons

B. Euphoriants
1. Nitrous Oxide—laughing gas
2. Amyl Nitrite—"poppers"
3. Butyl Nitrite—"rush"

C. Tobacco

D. Cannabis

E. Laxatives and other over-the-counter drugs

IX. Break

X. Relationship of Other Drug Abuse to Woman Abuse

Major Point #7: The connections between other drug abuse and woman abuse are not as well researched as the connections between alcohol abuse and woman abuse.

There are two different kinds of connections:

1. Women who are physically abused by their partners often abuse other drugs themselves, particularly minor tranquilizers such as valium and librium. Many battered women go to their doctors and receive prescriptions for minor tranquilizers or sleeping pills. Gayford, in a study of 100 battered women, found that 71 of them had received prescriptions for minor tranquilizers at one time or another and none of them had discussed the beatings with their doctors.
2. Men who batter women may also be abusing other drugs. Dane County Advocates for Battered Women statistics show alcohol abuse as far more prevalent than other drug abuse. However, marijuana abuse is fairly common, and cocaine and amphetamine abuse is occasionally reported. One interesting observation is that veterans (particularly Vietnam veterans) who are beating their partners are often reported to have other drug abuse problems.

Related to the above, advocates need be aware of the following intervention.

1. Always ask women about their use of prescription drugs. When were they prescribed and why? What effects do the women feel they have?
2. Advocates can give women information about tranquilizers—the effects, dangers, appropriate uses.
3. Always ask about other drug abuse in the abuser (prescription and "street" drugs). Try to help the woman define what the effects seem to be on her partner's behavior.
4. If there are questions, the advocate should call the nearest drug information center.

XI. Evaluations

Introduction to Other Drug Abuse

Footnotes and References

[1] Much of this information originates from the Johnson Institute, Minneapolis, MN.

[2] A comprehensive booklet on other drugs is *You Asked for It,* from Wisconsin Clearinghouse, 1954 E. Washington Ave., Madison, WI 53704. $.70 ea. + $.50 (handling) + 10% shipping.

Session 3
Assessment and Intervention Techniques*

Purpose

To provide concrete examples of working with chemical abusers and their families and to give participants an opportunity to practice in role play situations assessment and intervention techniques.

Agenda

I. Check-in and Review of Homework
II. Short Review of Systems Approach
III. Common Pitfalls in Dealing with Chemically Dependent Persons and Their Families/Friends
IV. Confronting Our Own Use/Abuse
V. The Sociological Perspective
VI. Break
VII. Triads/Role Plays Using Examples from Their Experience with Clients
VIII. Large Group Discussion of Role Plays
IX. Evaluations

Objectives

At the end of this session participants will be able to:

1. Identify at least five common pitfalls in working with chemically dependent persons and affected family members.
2. Identify his or her own drug use (abuse) on a continuum and complete an assessment of his/her drug use.
3. Identify at least three issues or actions that may set off increased or decreased drug use for them personally.
4. List at least five messages on drug use commonly found in the mass media.
5. List at least three new ideas they have for working with families with a chemical dependency problem.

Notes to the Instructor

Necessary Equipment: Mobile, Handouts B and C Chalkboard or flipchart.

Homework: Ask participants to think about a family member or friend or acquaintance who has/had a drinking problem.

- What has been their reaction?
- Have they talked with this person about their drinking?
- What feelings have they had?

II. Short Review of Systems Approach

Look over the session on working with children from violent homes and review systems approach.

Major Point #1: When one member of a family changes, all family members are affected.

A fine way of illustrating this point is by using a mobile. If you pull on one part of it, all the other parts react. This is why chemical dependency in one person affects the whole family—they react to the dependent person.

III. Common Pitfalls

Major Point #2: The advocate should be aware of some common pitfalls in working with chemically dependent persons and affected family members.

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*This session was originally planned and presented by Judy Schector and Ann Schaffer of PICADA, 17 N. Webster, Madison, WI 53703

Use a chalkboard or flipchart to write some of these problems. Ask participants to think of additional ones.

1. When working with an affected family member, it is easy to **focus on the chemically dependent person.** It is important to focus on the affected family member, instead.
2. When working with an affected family member, we may **forget to assess his/her use of chemicals.** Many affected family members are also dependent.
3. Advocates can easily fall into the role of **enabler.** Many advocates can benefit from attending Al-Anon meetings to avoid this. Another way of avoiding becoming part of the sick family system is to have group staffing/supervision sessions with co-workers.
4. We may **focus too much on empathy, warmth and support,** which, by themselves, rarely change the sick family system. The advocate needs to use confrontation and paradox.
5. It is easy for the advocate to feel like a detective around AODA problems. It is OK to confront people on a feeling, hunch or intuition—you don't have to prove anything. Any facts/data you do have may be useful in breaking through the denial system.
6. Watch **that the person with whom you are working does not turn the situation around and focus it on you.** For example, "Well, what about you? You must use drugs?!" You can acknowledge your own use (if you use) but remind them that you are there to work on their problem—not to determine if you have one.
7. Remember, the process of coming to terms with chemical dependency is a long one. You are unlikely to have **instant successes.** Still, what you are doing may be furthering the abuser or affected family member along in this process. Don't become **discouraged** if you cannot see results from your work.

IV. Confronting Our Own Use/Abuse

Major Point #3: The advocate must confront her/his own use of chemicals and potential abuse in order to comfortably reach out to chemically dependent people.

Everyone uses some drugs in our society. Each of us is on a continuum of responsible use to chronic abuse. Each of us has the potential to abuse drugs. Have participants consider their own drug use. Is there some drug/chemical that they abuse? Coffee? Cigarettes? Sugar? Have folks divide into dyads and discuss their own drug use. Is there something they have tried to cut down on? Are they using some drug more now than they used to? Why? What kinds of things make them increase or decrease drug usage? (For example, an extra difficult period at work might set off an episode of increased drinking. Or, not getting enough sleep might justify a higher consumption of coffee, etc.)

Have each participant then fill out an assessment of his/her own drug use and of his/her reactions as an affected family member. (See handout B in Appendix E.)

These assessments are for the participant alone. If anyone is willing to share any new insights he or she had when filling out the assessment, that is fine, but participants should understand *before* filling out the form that they will not be required to share it.

V. The Sociological Perspective

Major Point #4: Chemicals are seen as powerful and valuable forces in this society, not simply as relief for physical ailments, but also as relief from emotional and even social problems.

Ask participants to share their scrapbooks of references to drugs. Discuss some of the messages that are being offered and list them on the chalkboard. What are the attitudes being portrayed? For example, drugs can cure unhappiness, can make young people grow up, can make social ineptness disappear, etc. Are there different messages for men and women? Have participants discuss how they personally buy into these messages. What might be the connection to battered women? Men who batter? Emphasize that none of us can escape at least some of the influence of these messages.

VI. Break

VII. Triads/Role Plays

Major Point #5: Practice may not make perfect, but it does help us become more comfortable with situations which may arise.

Break into triads and have people role play the situations they brought as part of their homework. One person is the advocate; one person is the person with whom he/she is working; and the third person should observe and comment.

Leave plenty of time for this section and the discussion following.

VIII. Discussion

IX. Evaluations

Session 4
The Family Illness*

Purpose

To introduce counselors to the family dynamics that make chemical dependency a family illness and to give them some basic intervention tools and ideas to use with family members.

Agenda

- I. Check-in and Review of Homework
- II. The Family Illness
  - A. Disease concept as it applies to family
  - B. Family dynamics
  - C. Family progression
  - D. Family roles
    - 1. Dependent
    - 2. Enabler
    - 3. Hero
    - 4. Scapegoat
    - 5. Lost child
    - 6. Mascot
- III. Break
- IV. Film
- V. Treatment
  - A. Assessment
  - B. Working with the family member
    - 1. Groups, individual, couple, and family work
- VI. Evaluations

Objectives

At the end of this session, participants will be able to:

1. List at least five effects of chemical dependency on the affected family members.
2. Describe at least five family dynamics common to families of chemically dependent people.
3. List in order at least five points on the progression chart for family members.
4. Define "enabler."
5. List at least five assessment questions to ask affected family members.

Notes to the Instructor

Necessary Equipment:
Film
Screen
Projector
Handouts
Evaluations

If you can obtain any of the following pamphlets, they would be good handouts, too.

1. *The Enabler: The Companion to Chemical Dependency*, Johnson Institute, 10700 Olson Memorial Highway, Minneapolis, Minnesota 55441.
2. *Al-Anon: A Message of Hope*, by Joseph L. Kellermann.
3. *Free to Care: Therapy for the Whole Family of Concerned Persons*, by Terence Williams.

Both 2 and 3 are from Hazelden, Box 176, Center City, Minnesota 55012.

4. *The Family Illness of Alcohol/Drug Dependency*, by Daniel Budenz, Progressive Literature, Box 278, Middleton, Wisconsin 53562.

Homework: Have participants think of families with whom they have worked that had both chemical dependency problems and violence. They should come to the next session prepared to discuss issues and concerns about these families.

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*This session was originally planned and presented by Judy Popham and Claudia Greco of Madison General Hospital, Alcoholism Program and Education Center (APEC) Outpatient Clinic.

I. Check-In
Review of Homework

II. Family Illness

Major Point #1: When one person in a family is abusing alcohol and/or other drugs, the whole family becomes adversely involved, developing some very specific symptoms. The pattern of these symptoms is so predictable that it is known as the family illness.

As a family disease, chemical dependency is both personal and systematic; it affects each family member as an individual and the family system as a whole. Each member is constantly having to react to what another member has done and to do so in a way that offers some promise of stability for him/herself. Family members' behavior can be understood only when it is seen realistically, as an equal and opposite reaction to the dysfunctional attitudes and actions of the chemically dependent person.[1]

It is important to stress that the family members are not sick or abnormal before the abuse begins but their illness is a reaction to the loved one's abuse. A Hazelden pamphlet by Terence Williams describes the family illness as an addiction.

In some terrible way, the family's struggle to control the addict's behavior or somehow to escape from the consequences of his behavior begins to govern the family's whole lifestyle. As the family struggles to cope, typically they become bound up in a destructive pattern of recurring, predictably bad situations. Just as the addict himself suffers, they suffer deeply, but they can't seem to bring about any kind of change in their lives. It is our observation that concerned persons become addicted to the addict in much the same way he is addicted to drugs.[2]

Major Point #2: The counselor should be aware of the family dynamics in an abusive family.

As the chemical dependent person becomes progressively more abusive, the family dynamics become increasingly predictable and focused on the chemical dependent's behavior. Family members become preoccupied with controlling the drinker's behavior through tactics such as preaching, ignoring, pouring bottles down the drain, flushing pills down the toilet. The average family will at first try to ignore the problem drinking. This stage lasts on an average of 6-8 years, and it is another 2-3 years before the partner generally decides to seek help.[3] As in any family with a major disruption or illness, survival becomes the key issue. In this family dynamic the spouse takes control of the family and tries to minimize the adverse effects of the alcoholic's behaviors. At least this is true when the alcoholic is the man—nine out of ten wives stay with their alcoholic husbands and attempt to hold on to their marriage. However, nine out of ten husbands leave their alcoholic wives.[4] Women are obviously much more likely than men to feel that they must try to preserve the marriage. As Joseph L. Kellerman writes, ". . . To be kind, loyal, forgiving, understanding, forbearing, patient and loving—she is doing exactly what her family of origin, her church, her society and her culture expect of her. In fact, virtually demand of her!"[5] In families that stay together their growing obsession with attemping to control the alcoholic's behavior dictates a progressive sick pattern.

Major Point #3: Just as with chemical dependency, the family illness has an identifiable progression.

Pass out Handout D and go over the family progression chart with the participants.

Major Point #4: Not only is the family disease progressive, but it also forces family members into roles for coping.

Pass out Handout E and discuss the systems dynamics of the alcoholic family.

Every family member becomes to one degree or another an "enabler" of the chemically dependent person. That is, as they react to the addict they unwittingly conspire with the illness and *enable* it to progress to more serious stages. An enabler is an individual who reacts to the addict's behavior in such a way as to shield the addict from experiencing the full impact of the harmful consequences of the disease. Enablers are well intended and yet destructive. Anyone who lives with an addict is an enabler. The enabler typically excuses the addict's inappropriate behavior, withdraws from intimate contact with the addict, and tries to control the addict's behavior. The enabler's self worth becomes directly tied to the addict's chemical use. It is important to note how similar this behavior is to that of the battered woman. The enabler can only get well when she refuses to accept responsibility for another person's behavior and begins to act positively in her own behalf.

III. Break

IV. Film

See the list of recommended films.

Questions to ask after the film might be:

1. How did the film affect you?
2. Did you identify with any of the characters?
3. What similarities did you see between family members in this film and those in violent families?
4. How can the acting/reacting cycle, the game without end, be broken?

V. Treatment

Major Point #5: Family members, like addicts, can and should be assessed to determine how involved they are in the system. The assessment can also be used as an indirect intervention in confronting the family member as to how obsessive they have become.

Pass out Handout #12, #13, and #14. The questions on Handout #12 are an assessment for alcohol and other drug problems. All family members should be assessed for chemical dependency as it has been found that approximately 50% of all affected family members are also chemically dependent. The questions on Handouts F and G are designed to assess family illness—geared towards adults and children, respectively.

Anyone who mentions that a partner may have an AODA problem should be assessed. One of the important messages of the assessment is that it concentrates on the non-addicted partner, making them focus on themselves instead of the abuser/dependent.

Major Point #6: Whether or not the chemically dependent person seeks help, the family members can receive help and learn to consider themselves first.

Like battered women, the partner of a chemically dependent person is used to putting other family members, including the abuser, before her (him) self. For a woman, learning to put herself first can be very difficult as it goes against the image of what a wife and mother should be. She has to be helped to see that putting herself first can be beneficial to her, to her children, and even the abuser. She also needs to be confronted on her insistence that somehow she is responsible for or can control the abuser's behavior.

If the abuser is in treatment, the family members will still need help, too. Ideally, the whole family will get treatment in the form of peer groups. Peer groups such as Al-Anon, Alateen and Alatot have been proven especially helpful for family members. Individual sessions in the beginning may be helpful, but family members are more likely to get what they need in groups. This will be examined more closely in Session #8.

The Family Illness

Footnotes and References

[1] Wegscheider, Sharon. *Another Chance: Hope and Health for the Alcoholic Family* (Palo Alto, CA: Science and Behavior Books, Inc.), 1981. p. 80.

[2] Williams, Terence. *Free to Care: Therapy for the Whole Family of Concerned Persons.* ©1975. Hazelden Foundation, Inc., Box 176, Center City, Minnesota 55012. p. 6.

[3] Kellerman, Joseph L. *Al-Anon: A Message of Hope.* ©1976 by Joseph L. Kellerman. Hazelden Books, Box 176, Center City, Minnesota, 55012.

[4] Langone, John and Dolores de Nobrega Langone, *Women Who Drink* (Reading, Mass.: Addison-Wesley Publishing Co.), 1980. p. 27.

[5] Kellerman, op cit., pp. 6-7.

Other References

Johnson Institute, Inc.
10700 Olson Memorial Highway
Minneapolis, MN 55441
1-612-544-4165

Books, pamphlets, films, consultation and training

Onsite Training and Consulting, Inc.
1645 Hennepin Ave., Suite 206
Minneapolis, MN 55403
books, pamphlets, films as well as consultation and training

Al-Anon Family Group Headquarters
P.O. Box 182 Madison Square Station
New York, NY 10159
Books, pamphlets.

Compcare Publications
2415 Annapolis Lane, Suite 140
Minneapolis, MN 55441
1-800-328-3330

Session 5
The Connection Between Chemical Dependency and Family Violence

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See Chapter II, Women Abuse, Session #4.

Session 6
Working With Children From Chemically Dependent Families*

Purpose

To provide participants with an understanding of the dynamics involved in alcoholic families and some ideas for assessing and working with children from these families.

Agenda

- I. Check-in and Review of Homework
- II. Overview of Affects
  - A. Film (*Soft is the Heart of the Child* or "Drink, Drank, Drunk" section of *Children*)
  - B. Basic information of affects
- III. Common Feelings of Children
- IV. Break
- V. Dynamics in Chemically Dependent Families
- VI. Roles Children Play
- VII. Roles Parents Play
- VIII. Roles of Recovery and Treatment
  - A. Individual sessions
  - B. Group techniques
- IX. Evaluations

Objectives

At the end of this session participants will be able to:

1. List at least two statistics on the extent of risk involved for the children of alcoholics.
2. List three common feelings of children of alcoholics.
3. Identify and explain three family dynamics which serve to trap children in the system.
4. Identify and define three common roles of children from alcoholic families.
5. List at least three reasons why children from alcoholic homes need treatment themselves.

Notes to the Instructor

Necessary Equipment:	Film. Projector and screen. Chalkboard or flipchart. Evaluations.
Homework:	Ask the participants to consider women with whom they have worked who had chemical dependency problems. They should come prepared to discuss these cases at the next session.

Major Point #1: Children of alcoholics are at risk for all kinds of problems.

Show the film after this introduction. Some questions following the film might be:

1. What feelings do you think the children were having?
2. How do you think growing up in a home with an alcoholic parent might affect your world view?
3. How did the siblings support and/or react towards each other?
4. What kind of relationship did the children have with the non-alcoholic parent?

The statistics are clear around the risk involved for the children of alcoholics.

- One study reported that 52% of the alcoholics in the sample were themselves children of alcoholics.[1]
- An estimated 15 to 17 million children in this country have an alcoholic parent and many more have a parent addicted to some other drug.[2]
- Another study found that among non-alcoholic wives of alcoholics, 60% had had an alcoholic father.[3]
- Other common problems for children of alcoholics include placement in foster homes, marriage under age 16, juvenile delinquency, mental illness, and suicide.[4]

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*This session was originally planned and presented by Joyce Grzeskowiak, ACSW, Clinic Supervisor, Madison General Hospital APEC Outpatient Clinic, Madison, Wisconsin.

Major Point #2: Children of alcoholic parents experience some common feelings which counselors should be aware of in their contact with these children.

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1. Guilt

Children of alcoholics tend to feel that if there is something wrong with their families, there is something wrong with them. This guilt is exacerbated by the family's refusal to talk about the alcoholism. Or the children may be blamed for the drinking ("If you would stop getting into trouble, I wouldn't drink so much"). Guilt also may emerge in the child as the response to his or her behavior are unpredictable. Children notoriously blame themselves when things are not right in the family. Children may have great difficulty balancing their love for the alcoholic parent and their hatred of the drinking.[5]

2. Confusion

Alcoholism subjects the entire family to constant stress and fears of various kinds. Children may have to learn rules at home which cause them to act totally differently from the ways they act outside of the family. The family rules may seem "crazy" to outsiders. Sharon Wegscheider outlines the following rules of alcoholic families:

a. The dependent's use of alcohol is the most important thing in the family's life.
b. Alcohol is not the cause of the family's problem.
c. Someone or something else caused the alcoholic's dependency; he is not responsible.
d. The status quo must be maintained at all cost.
e. Everyone in the family must be an "enabler."
f. No one may discuss what is really going on in the family, either with one another or with outsiders.
g. No one may say what he is really feeling.[6]

Trapped in this very disordered system, children are generally quite confused.

3. Powerlessness

Of course, the drinking itself becomes the all powerful force in the family. The child can do nothing to control it (although he/she will keep trying). "The children's feelings are often reflected in loss of sleep, feelings of hopelessness, and alienation from the family and from themselves; they feel totally powerless to make the situation disappear. They come to consider themselves pawns in a game which they do not understand, or victims of a battle they cannot escape."[7]

Major Point #3: Three family dynamics trap the children in the system: the No Talk Rule, a reversal of roles (parent-child), and the denial of the dependency.

As Sharon Wegscheider says of the No Talk Rule:

> *'This is exactly the sort of rule we would expect in a system as unhealthy and closed as an alcoholic family. Feeling threatened, the rulemaker tries to avoid, first, letting people outside know about family affairs—specifically, the degree of his dependency and the magnitude of its impact on his wife and children—and second, letting family members have access to new information and advice from outside that might undermine their willingness to enable.*[8]

The No Talk Rule can be symbolized as if there is an elephant in the living room and everyone walks around it, pretending it is not there.

One result of the No Talk Rule is the isolation of the child. The child is forced to see the drinking as the dominant issue in his/her life, but then cannot talk about it. It becomes something so horrible, so shameful that it cannot be mentioned. The issues which other children discuss among themselves may seem trivial in comparison. The child may be incredibly lonely.

The child may react to the disrupted family by taking on a parental role. According to Ackerman, these children may see themselves as extremely mature for their age.[9] They may take on some of the responsibilities of the parents such as housekeeping or cooking. Particularly, the oldest child may become the main parental figure for the younger children. Indeed, the nondependent spouse may rely on an older child to act as a co-parent and confidante.

Finally, the whole family spends much energy denying the dependency. This denial, which begins with excuses for slightly unacceptable behaviors and overcompensating for the dependent's tasks left undone, grows into a system which acts as a screen to prevent family members from seeing the realities of their situations. They become blind accomplices. This screen results in constant misinterpretations of daily events. Family members make decisions with important data missing because of this denial. This blindness perpetuates the disease—the so-called "Merry-go-round named Denial."[10]

Major Point #4: The children of alcoholics are generally forced into roles to cope with the family system. The common roles are: "hero," "scapegoat," "mascot," and "apathetic" child.

These roles were briefly mentioned in Session II: The Family Illness. The "too good to be true" is the child whose behavior is too good to be true. The oldest child is most likely to play the **hero** role. The hero is both helpful inside the family and successful outside. He/she may take on parental responsibilities at home, get good grades in school, be good at sports or music. He/she calls attention to the family by confirming that all is not bad, they must be doing *something* right. For this reason, he/she receives more parental attention than other siblings and is likely to have a basic sense of self worth. However, he/she has set up an impossible task—that of making the whole family "normal" by being good. The problem is that no matter how good he/she is, the situation gets worse. For that reason, the hero always feels inadequate and guilty.

The **"scapegoat,"** who is often the second child, takes the opposite role. Seeing that he/she is unable to ever outdo the hero, the scapegoat chooses to get attention by being bad. The scapegoat is too bad to be true. The scapegoat, starved for attention, gets it the only way he/she sees possible—by acting out. The personal cost of acting out this role is enormous. His/her sense of worth, both in his/her own eyes and other eyes, becomes almost totally destroyed. The scapegoat often seems consumed with anger—sullen and uncooperative or openly rebellious. The scapegoat's behavior may bring the family into treatment initially.

The **"mascot"** is usually a third or fourth child, most often the youngest. He/she is often protected by other family members. The mascot learns to clown and show off to get attention. The mascot's behavior puts him/her in control of the family while he/she has their attention, relieves the tension with humor, and takes the focus off the alcoholic again. The mascot has trouble growing up. He/she may fear for his/her sanity because of the constant protection. He/she may feel quite delicate and unable to take care of him/herself. If anyone is going to have severe psychiatric problems, it is the mascot.

The **"apathetic" child** adapts by becoming a loner, staying out of everyone else's way. In his/her own world, he/she can control outcomes. This child is often "forgotten" by the parents, too. However, because he/she spends so much time alone, he/she gets very little experience in interacting. The lost child has no experience of close, living relationships.

Major Point #5: The parents play roles with their children by denying that problems exist, blaming the children for the drinking, and/or manipulating the children.

We have discussed how the parents react to reinforce the children's chosen roles. The alcoholism is always denied, so other explanations for family problems are sought. The rebellious child is generally blamed. The children may be used as buffers between the parents or manipulated to act as a defense or helper for one parent or another. In the beginning the nonalcoholic spouse makes excuses for the children when they ask where the alcoholic parent is. When a parent is alcoholic, parental roles are most often marked by inconsistency. The alcoholic parent may seem like two or more different personalities to the child. The other parent is often too beset with tension to parent consistently.

Major Point #6: Family treatment is the best hope for preventing alcoholism and drug dependency in the next generation.

The alcoholic family before treatment seeks to establish a false equilibrium within the family to survive. Each family member develops its own role which helps them to survive but not live. The dependent family in treatment needs to establish a new true equilibrum and subsequent roles.

We have seen how children are affected by alcoholism/other drug abuse by a parent. According to Wegscheider, an effective family treatment program exposes the alcoholic family system for what it is, helps the family make its system more open and flexible, and nurtures each family member to wholeness. While family members may benefit from individual counseling, particularly in the beginning, groups have been used successfully. Groups end the isolation, teach social skills, and help the members learn from each other. Children can benefit from peer groups and family groups. Alateen and Alatot are self help groups for teenagers and younger children.

If possible, invite someone from these groups to come in and explain how they function. You could end this section with this explanation or a display of group technique.

IV. Evaluation

Working With Children From Chemically Dependent Families

Footnotes and References

[1] Pierce, Jill. "Alcoholism: A Family Disease," in *Alcoholism and Recovery Within the Naval Service,* 1976.

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[3] Ibid., p. 30.

[4] Ibid.

[5] Ackerman, Robert J., *Children of Alcoholics* (Holmes Beach, Florida: Learning Publications, Inc.), 1978. pp. 24-28.

[6] Wegscheider, op. cit., pp. 81-83.

[7] Ackerman, op. cit., p. 27.

[8] Wegscheider, op. cit., p. 83.

[9] Ackerman, op. cit., p. 23.

[10] Kellerman, Joseph. *Alcoholism: A Merry-Go-Round Named Denial* (New York, N.Y.: Al-Anon Family Group Headquarters, Inc.), 1969.

Session 7
Working With the Woman Chemical Abuser*

Purpose

To acquaint participants with the special problems and needs of female alcoholics/drug abusers.

Agenda

I. Check-in and Review of Homework
II. Society's Attitude
III. Why Women Drink Abusively
IV. How Women Drink
  A. Polydrug abuse
  B. Special patterns and problems
V. Break
VI. Treatment Indications
  A. Women for Sobriety
  B. Women's groups
VI. Evaluations

Objectives

At the end of this session, participants will be able to:

1. Identify at least three differences between society's attitudes towards women alcoholics and men alcoholics.
2. List at least three prevalent forces behind women's drinking.
3. Identify at least two special problems for lesbian alcoholics.
4. Name at least one statistic on the extent of prescription drug abuse by women.
5. List at least seven special problems and/or abuse patterns of women who abuse alcohol.
6. List at least three reasons why groups for women are effective forms of treatment.

Notes to the Instructor

Necessary Equipment:

Handouts: Copies of *Alcohol Abuse and Women: A Guide to Getting Help* by Marian Sandmeier, available from the National Institute on Alcohol Abuse and Alcoholism and from Wisconsin Clearinghouse.
Evaluations.

Homework: None.

II. Society's Attitude

Major Point #1: Because of society's attitudes towards women in general and women who abuse chemicals in particular, women's patterns of abuse and the consequences of that abuse differ from those of men. These differences must be taken into account when working with women abusers.

According to Langone and Langone, who wrote *Women Who Drink*, society's attitude toward the drinking woman seems to be a three-pronged approach: disgust, denial, and protection.[1]

One of the stereotypes that perpetuates these attitudes is the belief that women are the guardians of morality. Therefore, a woman's drinking problem must be denied or abhorred—she could not be a *real* woman. A drunk woman is violating a strong social standard.

Patricia C. McGuire writes:

'For one thing, social 'protectionism' has placed many women in situations more conducive to concealed and secret drinking and drug taking than men are typically placed in. For another thing, society has placed far greater stigma on women alcoholics and addicts than has been true for men, thus putting a premium on hidden drinking and drug taking. Accordingly, women have had a greater opportunity to progress to the advanced stages of chemical dependency before detection, and a greater motive for concealing and disguising their illness.'[2]

Said another way in a Department of H.E. & W. pamphlet:

'As a group women suffer a great deal of stress—and some of the stresses are very different from those faced by men. Since the traditional roles society has defined for women and

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*This session was originally planned and presented by Marcia Geiger, Dane County Mental Health—Alcohol Treatment Unit, Madison, WI.

men produce quite different behavior, goals, self-images, and life experiences, women face certain problems in common that are not relevant to men. From childhood, women have been taught that as the "second sex," they are expected to derive their sense of self-worth primarily through relationships rather than through achievements and activities of their own. Until recently, women were rarely encouraged to develop as independent persons with strong, secure identities. This is not to say that women's drinking problems stem entirely from their role in society. But regardless of what women do with their lives, they cannot escape society's judgement that, on some very basic level, they are inadequate because they are women. Studies repeatedly show that women drink primarily to relieve loneliness, inferiority feelings, and conflicts about their sex role, regardless of their lifestyle.[3]

A woman drinking and a man drinking, simply because of society's sex role expectations, will exhibit different abuse patterns, drink for different reasons, and have different needs around treatment. Estimates range as high as 8.5 million women in the United States with alcohol-related problems.[4] Another estimate shows that about 1 out of every 20 women in the U.S. today may be facing some kind of alcohol problem.[5] This is no small problem. All advocates should definitely be asking women they work with about their drinking habits.

III. Why Women Drink Abusively

Major Point #2: While there is no typical female drinker, there are several prevalent forces behind women's drinking including lack of self-esteem, stress, hereditary and environmental influences, and social and cultural forces.

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1. Lack of self-esteem

Women often devalue themselves. It is not unusual for women to regard men as superior to women. Women are much more likely to be treated for depression than men.[6] Women are taught to feel and act helpless, to be dependent. Women are encouraged to be passive which limits their abilities to actively seek happiness and fulfillment for themselves. Women, especially working women, must also face the pressure of conforming to society's expectations—of being a supermom without showing *any* weakness on the job.

On the other hand, women feel more pressure to act and be feminine—to prove that a working woman or liberated woman can also be feminine. Women often drink to achieve a sense of womanliness, according to Dr. Sharon C. Wilsnack, of the Clinical Psychology Service of the Massachusetts Mental Health Center and the Harvard Medical School.[7] The female alcoholic often experiences chronic doubts about her adequacy as a woman. Langone and Langone write, "all of these psychological fears—the fear of failing, of appearing unfeminine—are tied to a woman's self-esteem: If she fails at what society has determined to be important (or what she perceives as important), she has failed as a woman. And sometimes alcohol helps blot out that failure."[8]

2. Stress

Stressful life events are more likely to be reported as playing a role in problem drinking for women than for men.[9] Such events may include divorce, abortion, dysmenorrhea, death of a family member, alcoholism or mental illness in the family, desertion by a lover, menopause and the empty nest syndrome.

3. Hereditary and environmental influences

Some factors particularly related to women are the female metabolism, hormones, and body weight. Other factors such as alcoholism in the family of origin, learned behaviors, etc., are similar to those for men.

4. Physiological causes

Premenstrual tension and menopause have been implicated in female problem drinking by some researchers.[10] Studies have shown that a significantly higher level of blood alcohol is registered by women during the premenstrual phases of their cycles. The medical histories of alcoholic women reveal a high incidence of surgical operations performed on the uterus or ovaries.[11] However, studies on the relationship between alcohol abuse and female physiological functions remain inconclusive.

5. Social and cultural forces

Many of these have already been discussed. One area not yet touched on, however, are the special problems of lesbians. Lesbians, because of their even greater alienation from and devaluement by society, face added risks for alcohol abuse. There is still very little data on how lesbian drinkers do and do not differ from non-gay women drinkers. However, it is easy to extrapolate that the low self-esteem and stress are often even greater problems for lesbians, as well as the extreme cultural malignment, of misunderstanding, and discrimination against lesbians. An added problem for lesbians is the limited availability of social outlets. Generally, gay bars are one of the few places where lesbians can freely and comfortably gather. Obviously, there is an emphasis on drinking in these bars.

Another problem lesbians have is with treatment facilities which regard lesbianism as aberrant as abusive drinking. Many times lesbians hide their sexual orientation during treatment. If they don't, they are sometimes prevented from seeing their lesbian partners and their relationships are not treated seriously.

In conclusion:

'Women alcoholics, then, are a heterogeneous group. They sometimes drink for the same reasons that men do, and they often have, as do men, an alcoholic parent. But their reasons for drinking can also differ from men's and even from other women's . . . She has a lot of company, both men and women, and she is, in that sharing, more an equal than she was in the traditional American role that society expected of her and which may have driven her to drink."[12]

IV. How Women Drink

Major Point #3: Women are more likely than men to be polydrug abusers.

Women are by far the principal users of certain prescription medicines—tranquilizers, hormones, amphetamines (for dieting), and barbiturates (sleeping pills). More than 30 million women in the U.S., according to the National Institute on Drug Abuse, have taken tranquilizers, compared to 18 million men. Eighty percent of amphetamine prescriptions and two-thirds of the sleeping pill prescriptions are for women. Some 15 million women in the U.S. use combination estrogen-progesterone birth control pills.[13]

Women drinkers, then, have the added problems of multiple drug interaction which is likely to cause a more rapid progression, especially when her special female physiological and metabolic makeup are taken into consideration.

Major Point #4: Women who abuse alcohol have several special problems and abuse patterns which advocates must understand to be effective helpers.

Langone and Langone list the following issues:

1. Women drink, on an average, smaller amounts than men and prefer liquor and wine to beer.
2. Women buy less drinks than men, probably because men often pick up the check.
3. Women who drink a lot generally begin doing so at a later age than men, usually in their 30's, but once they start, their drinking problems develop faster and they appear to enter treatment at the same age as men (about 45).
4. Middle-aged women drink alone more often than men.
5. Many married women often tend to drink heavily on weekends or at parties, and not as frequently throughout the week.
6. Alcoholic women are far more likely to drink with a husband or a male companion than alcoholic men are to drink with a wife or woman friend.
7. Because of social stigma attached to a woman with a drinking problem, she is more apt to manipulate her environment to cover up her drinking.
8. Women who drink obsessively show up less often for treatment than men.
9. Some studies have suggested that more women than men drink when tense, crediting drinking with psychosocial benefits.
10. The steady drinking woman is less likely to delude herself into believing that she can stop when she chooses.
11. Women may be less inclined than men to continue drinking heavily while employed.
12. Alcoholic women complain of general dissatisfaction with sexual contact, and appear to have a high incidence of partial, if not complete, inability to achieve orgasm.[14]
    Other sexual issues:
    a. Many have been raped.
    b. Many have experienced incest.
13. Other research has suggested that along with sexual dissatisfaction, the alcoholic woman's marriage is often a nightmare.
14. Alcohol use/abuse during pregnancy can lead to more miscarriages, higher incidence of obstetrical and gynecological problems, and possible damage to the fetus (FAS—see session on that).

15. Finally, women are more likely than men to have the special issue of what to do with the children if they enter treatment, as well as a special fear of losing the children, either in custody fights or to child protection services. This is another reason women seek to hide drinking problems. Since many women don't have sympathetic husbands or partners to take care of the children while they go to treatment, they have no option for in-patient care.

V. Break

VI. Treatment Indications

Major Point #5: Women for Sobriety is a self help group, designed for women, based on a step program somewhat different from AA. Some women, but not all, may find this program more helpful than AA.

Women for Sobriety was recently founded by Jean Kirkpatrick to help women alcoholics develop a sense of self-esteem and positive attitudes in everyday life.[16] The thirteen statements of acceptance used in Women for Sobriety are:

1. I have a drinking problem that once had me.
2. Negative emotions destroy only myself.
3. Happiness is a habit I will develop.
4. Problems bother me only to the degree I permit them to.
5. I am what I think.
6. Life can be ordinary or it can be great.
7. Love can change the course of my world.
8. The fundamental object of life is emotional and spiritual growth.
9. The past is gone forever.
10. All love given returns twofold.
11. Enthusiasm is my daily exercise.
12. I am a competent woman and have much to give others.
13. I am responsible for myself and my sisters.

Some of the ideas of Women for Sobriety will make some women feel more comfortable — i.e., the non-religious emphasis, the all womens' groups, and the focus on acceptance and nurturance. Some women, however, will prefer AA which is more confrontive and paradoxical. In communities where there are both kinds of groups, women can be encouraged to try both before choosing one. Some women continue to attend both groups, getting different needs met in each.

Major Point #6: Groups restricted to women are often the most effective treatment for women.

Obviously at this point, groups for women are effective and important because of all these special needs women have. Women have traditionally been defined by men. Women's groups give them an opportunity to define themselves with support and ideas from other women. Women can confirm with each other that they are neither perfect angels on pedestals nor whores and sluts — there is an in-between. Women can learn to trust other women and have intimate friendships that are not based on sex. In womens' groups, women don't have to be concerned with presenting an image to the men in the group — they can be themselves. Women's groups are also a safe place for women to share any violence and abuse that has occurred. It is safe to talk about rapes or beatings and receive support.

Women's needs are different from men's. Some of the participants in the training may be able to add other ideas or concerns. An advocate must be particularly aware of these differences when working with women AOD abusers.

Working With the Women Chemical Abuser

Footnotes and References

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[2] McGuire, Patricia C., *The Liberated Woman,* a Hazelden Publication, Hazelden, Box 176, Center City, Minnesota 55012. Sixth Printing, March, 1980. p. 3.

[3] Sandmaier, Marian, *Alcohol Abuse and Women: A Guide to Getting Help.* U.S. Department of Health, Education and Welfare, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration. DHEW Publication # (ADM) 76-358, 1976. Available from Wisconsin Clearinghouse, 1954 E. Washington Ave., Madison, WI 53704. ($.50 each plus postage and handling).

[4] Langone and Langone, op cit., p. iii.

[5] Sandmaier, op cit., p. 5.

[6] Langone and Langone, op cit., p. 23.

[7] Ibid., p. 25.

[8] Ibid., p. 26.

[9] Ibid., p. 27.

[10] Ibid., p. 44.

[11] Lolli, Georgi, "Relation Between Alcoholism and Specific Feminine Physiological Functions," Connecticut Review on Alcohol, 5-3 (1953): 9-11.

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Session 8:
Fetal Alcohol Syndrome and Other Effects of Chemicals on Pregnancy*

Purpose

To describe Fetal Alcohol Syndrome and encourage counselors to pass on this information to women who drink.

Agenda

I. Check-in
II. Fetal Alcohol Syndrome
   A. What is it?
   B. Scope
   C. Re-discovery
   D. What causes it?
III. Effects of Other Drugs on Pregnancy
IV. What Can Counselors Do?
   A. Give information/prevention
   B. Identify babies/children with FAS symptoms
   C. Support women with alcohol-affected babies/children
V. Evaluations

Objectives

At the end of this session, participants will be able to:

1. List at least three physical manifestations of Fetal Alcohol Syndrome.
2. Recite at least one statistic on the extent of Fetal Alcohol Syndrome.
3. Identify how the Fetal Alcohol Syndrome and adverse affects on the fetus from other chemical usage can be prevented.
4. List at least three other drugs which appear to have teratogenic effects on the fetus.
5. Identify at least three ways that the mother's use/abuse of drugs may affect the unborn child.
6. Identify at least two interventions that an advocate can take to lessen this problem.

Notes to the Instructor

Necessary Equipment:	Handouts—pamphlets on FAS can be obtained from your local March of Dimes and Wisconsin Clearinghouse.
Homework:	Ask all participants to attend at least one Al-Anon or AA (open) meeting before the next session.

I. Check-in

II. Fetal Alcohol Syndrome (FAS)

Major Point #1: Fetal Alcohol Syndrome is a specific pattern of birth abnormalities caused by the mother's drinking during pregnancy.

Children with FAS have a pattern of defects including prenatal and postnatal growth deficiency, small head size with mental subnormality and facial abnormalities.[1] Other common defects associated with FAS are short eye openings, absence of the filtrum (the groove between nose and upper lip), hirsutism (inordinate profusion of hair on face at birth), epecanthic folds (folds on eyelids as in Down's Syndrome), underdeveloped jaw area, cleft palate, joint anomalies and cardiac anomalies. The adverse effects of maternal drinking during pregnancy are on a continuum with full-blown cases of Fetal Alcohol Syndrome on one end. On the less affected end of the continuum would be babies who are born simply with lighter birthweights. Streissguth calls attention to the fact that even infants who have no *physical* manifestations of FAS may be at risk of a variety of learning and behavioral handicaps such as hyperactivity, poor attention span, poor eye-hand coordination, slightly delayed development and mild learning problems.[2] Infants may manifest this damage to the central nervous system or brain by the following behaviors:

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*This session can be done in 45 minutes to one hour and therefore does not require a break.

1. Poor habituation, for example, when the infant is startled repeatedly by the same stimulus.
2. Jitteriness.
3. Decreased sucking pressure.
4. Disturbed sleep patterns.[3]

Major Point #2: Although estimates vary, Hall, who reviewed much of the available research findings, estimates that one or two in every 500 newborns will have fully developed FAS and one in every 50 newborns will have sustained some alcohol-related damage.[4]

In the *Fetal Alcohol Syndrome: Prevention, Intervention and Treatment Implications for Women and Children*, a report from the Wisconsin Governor's Joint Panel for the Prevention of Fetal Alcohol Syndrome, they estimate that approximately 3000 babies per year are born to women who drank heavily during pregnancy. The majority of these babies will manifest some symptoms of the Fetal Alcohol Syndrome.[5]

Major Point #3: Because of our society's ambivalent values and attitudes about alcohol use and abuse, Fetal Alcohol Syndrome was only recently re-discovered and documented.

As long as Plutarch and Aristotle there have been warnings against drinking during pregnancy. Early observations were that the children of heavy drinking women were "feebleminded" or "weak and sickly." On the other hand, alcohol was for years the only anesthetic and a cure-all. Alcohol has also been used in many rituals and religious ceremonies.[6]

Janet Wright states:

"In the early twentieth century, the pendulum of values swung from prohibition of alcohol to the pro-alcohol reaction of the forties and fifties. It was only a concern over the use of illegal drugs in the sixties that eventually led to the modern studies of maternal drinking during pregnancy. FAS was finally 'rediscovered' in 1973 by Jones and Smith, two specialists in birth defects at the University of Washington, and subsequently well documented through modern scientific research. Nevertheless, many still deny that alcohol can be harmful. Alcohol is, after all, still the American drug of choice."

Major Point #4: FAS and many lesser defects are caused by maternal drinking during pregnancy. The exact amount necessary to do damage and the most dangerous times to drink during the pregnancy are as yet unknown. Therefore, it is recommended that women not drink during pregnancy.

It has been found that the most dangerous time with most teratogenic drugs is during the first trimester of pregnancy, when the organs and brain of the fetus are forming. This is undoubtedly a critical time in terms of the effects of alcohol, as well.[8] Unfortunately, this is also the period during which a woman may not even know she is pregnant.

However, not only the first trimester is critical. Rosett found that women who were able to abstain or significantly reduce their alcohol intake before the third trimester until delivery had a significantly better chance of having a normal baby.[9]

All kinds of drinking are linked to birth abnormalities. Binge drinking – five or more drinks at a time – has been linked to brain malformations in some fetuses.[10] A social drinker who goes out partying only once or twice during her pregnancy could damage the developing fetus if the drinking occurred at a criticl period. And these critical periods in fetal development have not yet been determined. Why some babies are more affected than others may depend on their individual biochemical makeup and the time during their development at which the alcohol was ingested.

Not only do heavy drinkers risk bearing abnormal babies, but binge drinkers and moderate drinkers also risk damage to the fetus. The safest course is for pregnant women to stop all consumption of alcoholic beverages during pregnancy.[11]

III. Effects of Other Drugs on Pregnancy

Major Point #5: Other drugs also cross the placental barrier and many appear to have harmful effects on the fetus.

There are four ways in which the mother's use/abuse of drugs can adversely affect her unborn child: 1) the drug itself causing damage to the fetus in utero, 2) the problem of neonatal withdrawal, 3) other high risk factors associated with chronic drug abuse and, 4) other by-products of the dependent's lifestyle.

1. The drug itself causing damage. Several studies have been conducted and, although evidence still is inconclusive, PCP (angel dust), tranquilizers, and aspirin, as well as alcohol, all have been reported to have teratogenic effects.[12] LSD may cause a higher incidence of spontaneous abortions.[13]

2. The problem of neonatal withdrawal. Withdrawal symptoms have been documented in babies born to mothers who have been dependent on heroin, methadone, PCP, barbiturates, and alcohol. These symptoms include jitteriness, respiratory depression, lethargy, poor feeding, irritability, hyperactivity, tremors, diarrhea, fever, etc.[14]

3. Other high risk factors associated with chronic drug abuse. These factors include premature labor, breech birth, complications in delivery, eclampsia, etc.[15]

4. Other by-products of the dependent's lifestyle. The dependent pregnant woman may also damage the fetus through her lifestyle by not eating properly, not seeking early prenatal medical attention, and not taking care of other medical problems such as hepatitis, venereal disease, anemia, infections, skin disorders and dental cavities.

IV. What Can Counselors Do?

Major Point #6: One of the most important tasks is to simply inform all women about the dangers of drinking and other drug use during pregnancy.

Women of childbearing age as they come through the shelter or counselor's office should be informed about the dangers of chemical use during pregnancy. In a shelter or office this can be done simply by displaying an attractive poster or two or by setting out some brochures. With pregnant women, the message will need to be directed more clearly. Shelter advocates should simply give a little information to the pregnant woman. She should be encouraged to abstain from drug use during her pregnancy. Of course, in order to do this the advocate must be comfortable in advocating this position. This is not a moral stand—this is an issue of health and safety.

Major Point #7: An advocate who suspects possible Fetal Alcohol Syndrome or other adverse drugs effects in an infant or child should refer that child for an assessment by a doctor informed on the subject.

An infant who has been adversely affected by maternal alcohol or other drug consumption during pregnancy is likely to be difficult to care for. The infant will probably be irritable and have disturbed sleep patterns, which may affect the initial bonding process between mother and child. This baby could improve with a special program of enrichment and the mother could get more support. If you suspect possible chemical involvement, ask the mother about her drinking and drug usage habits during pregnancy. Give her information on the effects of drug usage/drinking during pregnancy and encourage her to take the child in for an assessment. It is important to acknowledge with the mother that she probably had no idea that her drinking or drug use could hurt her baby and that she never intended to do so. The mother's guilt over damaging the child may be overwhelming. She will need lots of support.

Children affected by chemical use during pregnancy should also be identified for two reasons:

1. To prevent chemical use in any future pregnancies of this mother.
2. To insure appropriate services for the child.

Major Point #8: All adverse effects caused by chemical use during pregnancy are preventable. They won't occur if the mother abstains from using chemicals during pregnancy.

This is the most important message to convey to all girls and women.

IV. Evaluations

Fetal Alcohol Syndrome and Other Effects of Chemicals on Pregnancy

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Session 9
Group Approach to Chemical Dependency*

Purpose

To explain why group treatment is most effective for chemical abusers and their families. To describe some different kinds of groups.

Agenda

- I. Check-in
- II. Differentiation Between Therapy Groups and Self-Help Groups
  - A. Self-help groups: AA, Al-Anon, Alateen, Alatot
  - B. Other groups
    - 1. Basic groups for chemical dependents and significant others
    - 2. Ongoing groups: women's group, couples group, psychodrama
    - 3. Workshops/seminars
    - 4. Family therapy
- III. Break
- IV. The Twelve Steps of AA, Al-Anon, Alateen
  - A. Discussion and explanation
- V. Winning by Losing – Use of Paradox
- VI. Evaluations

Objectives

At the end of this session, participants will be able to:

1. List at least 3 differences between self-help groups and therapy groups.
2. List at least 3 purposes of using a group approach to chemical dependency.
3. Explain denial.
4. Give an example of the paradoxical nature of AA/Al-Anon and how it can be used.

Notes to the Instructor

Necessary Equipment: Chalkboard or flipchart
Handouts: You might pick up some literature from your local AA; also Handout H
Evaluations
Homework: None

It may be good to invite some people who attend AA and Al-Anon to come to this session to answer questions.

I. Check-in

II. Differentiation Between Therapy Groups and Self-Help Groups.

Major Point #1: While self-help groups have been proven effective, structured therapy groups can often speed up the recovery process through the use of education, confrontation and direction. Treatment, however, is not a substitute for self-help groups.

Self-help

1. Peer group
2. Don't have to talk
3. Members recruited by attraction versus promotion
4. Free
5. Ongoing, life-long support
6. Readily available, worldwide, often daily
7. Indirect intervention
8. Individual totally responsible for recovery
9. Basis: personal experience of others.

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*This session was originally planned and presented by Judy Popham and Claudia Greco, Madison General Hospital, Alcoholism Prevention and Education Center (APEC), Madison, Wisconsin.

Therapy

1. Facilitated by professionals
2. Expected to relate
3. Program advertised
4. Costs money
5. Usually short-term, goal oriented
6. Available usually on weekly basis through hospital or mental health association
7. Indirect and direct intervention
8. Individual responsible but initially motivated by intervention and later assisted by counseling.
9. Basis: Scientific research + theory; accepted psychotherapeutic practice.

Although some individual counseling may be necessary for each family member, much of the work of chemical dependency can be done in a group, i.e. groups of peers, family, seminars/workshops. Since denial can be considered the #1 symptom of this disease, it can be seen that groups would be the most effective way of confronting denial. See Handout #H.

The following group structures and descriptions are taken from Madison General Hospital APEC out-patient program.

Basic Groups

The basic group experience provides an opportunity for clients to experience group interaction at a beginning level. Group members are continually encouraged to identify and develop skills needed to participate in a group setting. Sobriety counseling is stressed in chemical dependency recovery groups. Issues concerning recovery for family members are stressed in the basic groups for significant others.

Eligibility criteria includes:

1. A basic commitment to change and recovery expressed by the client.
2. Little or no knowledge of alcoholism/family illness.
3. Little or no prior group experience.

The following skill areas are identified and worked on during the basic group experience:

1. Communication skills—both listening and speaking.
2. Identifying and expressing feelings.
3. Giving and accepting feedback.
4. Problem identification.
5. Decision making.
6. Learning to take risks by sharing with others in the group.

Awareness exercises are utilized within the group in order to foster the development by the group participants of the above skills.

The basic group sessions are structured as follows:

1. Introduction and welcome to new members. Discuss recovery program, what you hope to work on in group.
2. Review group expectations and purposes, i.e., learning how to use group process to identify needs and to have those needs met, and identifying and utilizing the skills as stated above.
3. Announcements and report from group members on individual assignments, reactions to previous session in round-robin format.
4. Then a short period of quiet time before opening the group to those members who wish to work in group during that session.
5. During *Show and Tell* time, the group members are encouraged to share with the group a particular incident, comment, accomplishment, etc., that happened to them the past week. This exercise will provide an opportunity to "brag a bit" about themselves and will allow them an opportunity to receive compliments.
6. Work time—individuals are given time to focus on present problems or issues they would like group feedback and/or support on.
7. Termination Mirror—Members who wish to terminate from group share their thoughts and feelings about group experience. Describe their current plan of recovery. (AA/Al-Anon/Alateen meetings, sponsor contact, other outpatient participation). Group members provide their perceptions of individual's group involvement and recovery program.
8. Close with wrap up by therapists. Serenity prayer may be used to end each group.

Participation in basic groups can last anywhere from 5-15 weeks.

Ongoing Groups

Eligibility criteria varies according to the purpose of the group. Prior group experience, a commitment to change, participation in self-help group (AA, Al-Anon, Alateen) on a regular basis are basic requirements.

Ongoing groups differ in structure from basic groups. A brief check-in is done at the start of group and the rest of group time is work time. Basic recovery issues may be addressed, but the focus is more on "life problems."

Ongoing groups include groups for recovering chemically dependent adults, adult significant others, young peoples' recovery groups, adolescent significant others, children's groups. Ongoing groups are also provided to meet special treatment needs of the client population. Examples of current ongoing groups at APEC include the following:

Women's Group

Women's group is designed to provide a safe place for recovering chemically dependent women to develop a sense of their own individual needs and ability to meet those needs. The group structure enables recovering women to receive diversified feedback as well as provide a social situation in which to experiment with new coping skills. Skill development in the following areas is emphasized:

a. Feeling identification and expression
b. Communication—both verbal and non-verbal
c. Risk taking
d. Self nurturing
e. Decision making
f. Relaxation.

A female client will be considered for assignment to women's group if she demonstrates a need in any of the following areas:

1. Her primary relationship is under severe stress.
2. A lack of a healthy female support system.
3. A history of overly-dependent relationships with men to enhance self-esteem.
4. A history of competitive relationships with women rather than mutually supporting relationships.
5. Confused feelings about her sexuality.
6. A reluctance/fear to talk about sensitive issues in a mixed group.

The objectives of women's group are:

1. To provide a safe, nurturing environment which will allow trust and caring to develop with other women.
2. To explore the dynamics of past and present relationships and identify inaccurate expectations and perceptions of others.
3. To identify issues of uncertainty and fear in the area of sexuality.
4. To provide support and caring to women whose current primary relationship is under severe stress.
5. To learn to draw strength and energy from other women.
6. To clarify life issues which need to be addressed in order to achieve lasting, contented sobriety.

Couples Group Therapy

The couples group experience provides an opportunity for couples to re-examine their relationship, try new behaviors and enhance their present communication methods in a group setting. Since this group's primary focus is on relationships, past in-patient and/or out-patient treatment experience as well as 4 months sobriety are pre-requisites to participation.

Eligibility Criteria:

1. A basic commitment to change expressed by each partner.
2. Knowledge of chemical dependency and the family illness.
3. Prior group experience.
4. Regular AA and Al-Anon attendance for at least 4 months.
5. Abstinence from all mood or mind altering chemicals for at least 4 months for the chemically dependent person.
6. The completion of a relationship assessment by the group leaders to help identify issues to work on in the couples group.

The following skill areas will be identified and worked on during the couples group experience:

1. Active listening, summarizing, reflecting, self-disclosing, paraphrasing, and caring confrontation.
2. Feeling identification and expression.
3. Problem identification.
4. Risk taking, decision making.
5. Conflict resolution.

Psychodrama

Psychodrama offers the participant an opportunity to receive immediate support, understanding, and acceptance. It is an action form of therapy where individuals can dramatize, as opposed to merely talk about personal problems that contribute to an uncomfortable style of living. The most dramatic presentation of all, everyday life, unfolds before us continually. As we respond to the situations of everyday life, we cast ourselves as the star of this epic. We mask and costume ourselves, piece together our roles, and influence plot development. We become so involved in acting out our part that we seldom, if ever, take time to visualize the performance with detachment, objectivity, and the help of others to see if our trappings really fit us. Psychodrama provides a vehicle to do exactly that in a confidential setting. It provides a training ground where participants can express their anger, resentment, fears, love, and old memories; replacing negative attitudes, values, and behaviors toward new approaches to living. It enables a change from old means to new insights for courage, survival, and progress toward the fulfillment of human needs.

What can be learned through participation in Psychodrama:

1. Ability to identify and express feelings.
2. Communication skills—verbal and nonverbal.
3. Ability to give and receive feedback.
4. Ability to identify problems and means toward resolution.
5. An appreciation of one's uniqueness and commonalities with others.
6. Ability to make decisions.
7. An appreciation of life and willingness to take risks and complete group assignment toward change.
8. Spontaneity.
9. Awareness of one's potential.
10. Ability to enjoy life and have fun.

Psychodrama is open to both recovering chemical dependents and affected family members. As with all ongoing groups, clients attend until their personal goals have been clarified and achieved.

Workshops/Seminars

The primary purpose of workshops is the presentation of information. Use of workshops saves time and allows actual treatment sessions to focus on problems unique to the individual or family. Examples of workshops/seminars currently held at APEC are: weekly community seminars; a 2 day family program and a one day adolescent program—both being educational as well as experiential; a one day chemical dependency workshop; and alternatives therapy.

Other groups and services are offered based on need and availability of resources.

Family Therapy

Families are usually seen after each member has started an individual recovery program. As family members come to accept chemical dependency as a family illness, they find new hope that recovery is possible. An attempt is made to provide a safe and supervised setting where the family can begin to practice with one another the more open, honest feeling communication they have each been learning. The focus tends to be on process, not issues. Issues are important, but only as a context in which process can be observed and modified.

III. The Twelve Steps

Major Point #2: The twelve steps of AA/Al-Anon/Alateen are the crucial foundation to this program for healing oneself.

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1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God *as we understood him.*
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of characters.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God *as we understood Him,* praying only for knowledge of His will for us and the power to carry that out.

A.A.:

12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics, and to practice these principles in our affairs.

Al-Anon, Alateen:

12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to others, and to practice these principles in all our affairs.

Explanation of all the steps can be found in *Twelve Steps and Twelve Traditions,* Alcoholics Anonymous World Services, Inc.; Box 459, Grand Central Station: New York, New York, 10017; 1952, 1953.

Alcoholics Anonymous, Al-Anon, and Alateen offer powerful tools for recovery for chemically dependent families. It has been a most successful recovery program. It cannot be all things for all people. A favorite program slogan is: "Take what you can use and leave the rest behind." Major complaints about the program usually center around the language (patriarchal, heterosexist, "religious") and the spiritual base. Many people confuse religion and spirituality. A concept of "Higher Power" may be God, nature, energy shared, the group, love, etc.

The struggle to get healthy is one battle and the struggle to change institutions is another. Both are important in the long haul, but, at present, we have only imperfect institutions to help us work towards our own health.

Sharon Wegscheider, in her book *Another Chance,* describes the interplay of self-help groups and professional care, acting independently but in harmony, as creating a more complete environment for recovery than either can alone. The focus may shift from one to the other as the work progresses, but always the second is there reinforcing and being reinforced.[1]

V. Winning by Losing—Use of Paradox

Major Point #3: Using a paradoxical approach in dealing with the chemically dependent's denial of his/her problem and resistance to treatment allows the counselor/advocate to remain empathic, but still place responsibility for change on the person.

The therapist cannot force a person to change. Using paradox requires the belief that things are often not what they seem and that any statement also contains elements of its opposite. For example, according to AA, a person has to acknowledge defeat in order to experience liberation and acknowledge powerlessness to experience power, both of which are clearly paradoxical stances.[2] In fact, going over the 12 steps you can see that many of them are paradoxical. For example:

- You gain power by giving it away (to your Higher Power)
- Self-criticism leads to greater self-confidence and self-acceptance
- Elaborating your wrongs makes you able to let go of them.
- You maintain sobriety by giving it away to others.

The message in Al-Anon is also paradoxical. According to Jeffrey J. Shore:

"The basic paradox of Al-Anon is the following: Whatever seems 'natural' in dealing with Alcoholics, such as making excuses for them, do the opposite."[3]

The counselor/advocate can also use paradox to overcome resistance and increase motivation. If an alcoholic is refusing to go to AA meetings, you might agree with him/her, saying something like, "I guess you aren't really ready to try and get help. Perhaps you shouldn't do something good for yourself right now—you probably need to be in pain a while longer." This puts the alcoholic in a double bind.

Shore describes three categories of paradoxical techniques to use—neutralizing paradox, tranquilizing paradox, and energizing paradox. Neutralizing paradox is "a simple, unexpected, accepting reply to the alcoholic's provocative comments."[4] By not responding as expected, the counselor/advocate neutralizes the alcoholic's maladaptive behavior.

Example

Alcoholic:	"I'm sick of the way you work with me. I've half a mind to walk out and not come back."
Advocate:	"Hmmm—tell me more."

The use of tranquilizing paradox gives an alcoholic permission to not engage in a certain behavior, encourages him/her to postpone a difficult decision, or even prohibits an activity. An example would be forbidding a man who is afraid to be sexual with his wife when he is sober to have sex.

Finally, the energizing paradox includes prediction, proportionality, persuasion, reframing, prescription, practice, pedagogism, and positive provocation.[5] These tend to put the alcoholic in a double bind—opposing the advocate means behaving in a non-destructive manner. For example, the advocate can agree with a woman that she shouldn't look for a job yet as it would be too stressful.

The paradox along with empathy and concern can help overcome resistance and facilitate growth.

VI. Evaluations

Group Approach to Chemical Dependency

Footnotes and References

[1] Wegscheider, Sharon, *Another Chance: Hope and Health for the Alcoholic Family* (Palo Alto, California: Science and Behavior Books, Inc.), 1981. p. 216.

[2] Shore, Jeffrey J., "Use of Paradox in the Treatment of Alcoholism," *Health and Social Work,* Vol. 6, No. 1, February, 1981. p. 13.

[3] Ibid., p. 13.

[4] Ibid., p. 17.

[5] Ibid., p. 17.

Further Readings Available Through the Hazelden Foundation:

1. *Winning by Losing/The Decision,* The Caring Community Series #8.
2. Kellerman, Joseph, *Al-Anon. A Message of Hope.*
3. Williams, Terence, *Free to Care: Therapy for the Whole Family of Concerned Persons.*
4. Suift, H. A.; Williams, T., *Recovery for the Whole Family.*

Literature available through AA + Al-Anon World Services also. Catalog sent upon request.

A.A. World Services, Inc.
Box 459 Grand Central Station
New York, N.Y. 10017

Al-Anon Family Group Headquarters
P.O. Box 182 Madison Square Station
New York, N.Y. 10159

Session 10

Wrap Up/Staff to Staff Workshop

See Chapter II, Woman Abuse, Session 9.

Appendix A

Evaluation Forms

IN-SERVICE EVALUATION

Date and Place of In-Service ______________________________

Please rank the following aspects of the workshop on the 1 to 5 scale, 1 indicating a very negative reaction and 5 a very positive reaction.

		Very Negative				Very Positive
1.	Amount of new information presented	1	2	3	4	5
2.	Value of information to your professional development	1	2	3	4	5
3.	Variety of information	1	2	3	4	5
4.	Opportunities to participate and ask questions.	1	2	3	4	5
5.	Clarity of presentation by trainer(s)	1	2	3	4	5

6. The greatest personal insight I had today was...

7. What information/techniques presented today will be most valuable to you in your work?

8. Comments/criticisms/suggestions?

FOLLOW-UP FEEDBACK FORM

Name ______________

Date ______________

Agency ______________

1. Did your training increase your knowledge about family violence?

1 Not at all	2	3	4	5 Very much

2. Did your training help you change the ways you work with violent families?

1 Not at all	2	3	4	5 Very much

In what ways?

3. What have you found to be the most useful about the training in your work?

4. What was the least useful about the training in your work?

5. What would you still like more information or training on?

6. Any suggestions for us or other comments?

Thank you for your time!

Appendix B

Pre- and Post-Tests

PRE-TEST/POST-TEST ON FAMILY VIOLENCE

Name ____________

Date ____________

Agency ___________

T F

___ ___ 1. Battered women have as much protection under the law as any other crime victim.

___ ___ 2. In a violent alcoholic family, if you treat the alcoholism the violence will be eliminated.

___ ___ 3. Woman abuse occurs at least once in over one third of all marriages in the U.S.

___ ___ 4. Women with a traditional view of wife as the husband's helpmate are less likely to get beaten.

___ ___ 5. Most men who beat their wives also beat the children.

___ ___ 6. Children are not so affected by the violence between their parents if they don't see it.

___ ___ 7. Families become addicted to violence in patterns very similar to families addicted to alcohol.

___ ___ 8. The first thing to do with a battered woman is to explore her role in perpetuating the violence.

___ ___ 9. You should only ask about the possibility of violence in the family if you have reason to suspect it.

___ ___ 10. Men who are violent at home are also violent in other situations.

___ ___ 11. More men beat women than vice versa only because men are generally bigger than women.

___ ___ 12. It is as easy for a woman to leave a violent marriage as it is for a man.

___ ___ 13. Women stay in violent relationships partly because they are masochistic.

___ ___ 14. Men who beat women are either drunk or crazy.

T F

___ ___ 15. Sometimes a woman deserves to get hit because of the way she provokes a man.

___ ___ 16. A police officer can arrest a man if he is violating a civil restraining order.

___ ___ 17. If a person is drunk, he/she cannot control his/her violent behavior.

___ ___ 18. Children from families where the wife is beaten generally grow up identifying with and feeling closer to the mother than to the father.

___ ___ 19. Children from violent homes are likely to repeat that violence in their own marriages as adults.

___ ___ 20. Woman abuse is a relatively new phenomena.

___ ___ 21. Woman abuse is not as prevalent as child abuse.

___ ___ 22. Usually the violence in a relationship lessens as the partners mature.

___ ___ 23. Generally, after a violent episode, the couple experiences a period of more relaxed togetherness.

___ ___ 24. Batteres wives rarely beat or neglect their children.

___ ___ 25. Violent couples are extremely dependent upon one another.

___ ___ 26. Hitting children is an effective form of discipline.

___ ___ 27. If a woman gets a divorce, she will no longer get beaten.

___ ___ 28. Battered women are likely to be poor, uneducated, or from a minority group.

___ ___ 29. Women are as likely to be beaten when they are pregnant as when they are not.

___ ___ 30. Most men would not beat their wives if they were financially secure.

Developed by: Janet Wright
Dane County Advocates for Battered Women
110 E. Main; Suite 905
Madison, Wi. 53703

Appendix C

Recommended Films

On Child Abuse

1. "Incest, the Victim Nobody Believes" - Motorola

2. "Who Do You Tell" (for grade school ages)
   Motorola
   MTI Teleprograms, Inc.
   4825 N. Scott St.
   Schiller Park, IL 60176

3. "Ordinary People" (excellent introduction to child abuse)
   Available from MTI (address above)

4. Video tapes of Hank and Anna Giarretto's of San Jose, CA on sexual abuse:

   1. Overview
   2. Treatment
   3. Law enforcement

   Available to rent from Parental Stress Center, 1506 Madison St., Madison, WI 53715

5. "A Time to Speak" (child abuse)
   Available to rent from Parental Stress Center (address above)

On Woman Abuse

1. "We Will Not be Beaten"
   Available from Transition House Films, 120 Boylston St., Boston, MA

2. "Violence Behind Closed Doors"
   Available from Motorola
   MTI Teleprograms, Inc.
   4825 N. Scott St.
   Schiller Park, IL 60176

3. For other recommendations, contact National Clearinghouse on Domestic Violence, P.O. Box 2309, Rockville, MD 20852.

Men Who Batter

1. "Deck the Halls"
2. "Up the Creek"
3. "Shifting Gears"
   Available from: ODN Productions, 74 Varick St., Suite 304,
   New York, N.Y. 10013, (212) 431-8923.

On Chemical Dependency

1. "If You Loved Me"
2. "Soft is the Heart of a Child"
   Available from: Modern Talking Picture Service, 1687 Elmhurst Rd.,
   Elk Grove Village, Illinois, (312) 593-3250.
3. "The Family Trap" (with Sharon Wegscheider)
   Available through: Onsight Productions, 1645 Hennepin Ave.,
   Suite 206, Minneapolis, MN 55403, (612) 332-4474.
4. "The Enablers"
5. "The Intervention"
6. "I'll Quit Tomorrow"
   Available through: Johnson Institute, 10700 Olson Memorial Hwy.,
   Minneapolis, MN 55441, (612) 544-4165.
7. "Drink Drank Drunk"
8. "The First Step"

   Further Information available from: Hazelden Foundation,
   Consultation and Education Services, Box 176, Center City, MN 55012,
   1-800-328-9288.

Appendix D

Handouts on Woman Abuse

HANDOUT #1

WHY WOMEN STAY

SITUATIONAL FACTORS:

- Economic dependence
- Fear of greater physical danger to themselves and their children if they a-tempt to leave.
- Fear of emotional damage to children.
- Fear of losing custody of children.
- Lack of alternative housing.
- Lack of job skills.
- Social isolation resulting in lack of support from family or friends and lack of information regarding alternatives.
- Fear of involvement in court processes.
- Cultural and religious constraints.
- Fear of retaliation.

EMOTIONAL FACTORS:

- Fear of loneliness.
- Insecurity over potential independence and lack of emotional support.
- Guilt about failure of marriage.
- Fear that husband is not able to survive alone.
- Belief that husband will change.
- Ambivalence and fear over making formidable life changes.

Taken from Family Violence: Intervention Strategies
U.S. Department of Health and Human Services
Office of Development Services
Administration for Children, Youth and Families
Children's Bureau
National Center on Child Abuse and Neglect

HANDOUT #2

THE CRISIS ASSESSMENT - VICTIM PROFILE

HISTORY OF ABUSE? yes →

- Was victim abused previously? When did the last incident occur? Were weapons used or are they available to the abuser?
- Has victim been abused by current partner?
- Severity of past episodes? Degree of injury?
- Frequency of abuse?

LEGAL REMEDIES? yes →

- Has victim called police in the past?
- Has the victim taken court action before?
- Has the victim followed through on warrant?
- Has the victim followed through with a court hearing?

HISTORY OF SEPARATION? yes →

- Has victim separated from current spouse? How many times? Outcome?
- Has victim separated from previous spouse?

Taken from: Family Violence: Intervention Strategies
U.S. Department of Health and Human Services
Office of Human Development Services
Administration for Children, Youth and Families
Children's Bureau
National Center on Child Abuse and Neglect

THE CRISIS ASSESSMENT - VICTIM PROFILE

LIMITED ABILITY TO FUNCTION OR MAKE DECISIONS?

yes →

- Is victim capable of making decisions about how to avoid violence?
- Has victim developed a workable plan or is she immobilized?
- What barriers are preventing victim from making a plan?

CHILDREN AT RISK

yes →

- Are children in danger? Has there been previous abuse?
- Has victim made a decision to take the children in the event of separation?
- What are the best plans for the children?

IS VICTIM POTENTIALLY VIOLENT?

yes →

- Does the victim feel that in anger or rage she could use a wapon to harm the attacker?
- Does the victim have access to weapons?
- Does the victim plan to fight back?
- Has victim been violent in past?

HANDOUT #3

Therapists must:

1. Support women who have been victimized.
2. Not accept stereotyped myths about battering relationships.
3. Appreciate natural support systems in the community.
4. Be willing to help create new support systems.
5. Be willing to cooperate and untangle bureaucracy for unskilled clients.
6. Collaborate with other professionals.
7. Deal with their own fear of violence.
8. Understand how institutions oppress and reinforce women's victimization.
9. Be willing to deal with complicated cases.
10. Be willing to be role models for their clients.
11. Appreciate the work of non-credentialed para-professional
12. Be able to formulate their own outlets for anger.
13. Tolerate client's anger.
14. Tolerate horror stories and terrorizing events.
15. Allow their client to work through her issues without pushing too fast.
16. Allow clients to return to a violent relationship without becoming angry with them.
17. Respect and believe in people's capacity to change and grow.

Taken from Lenore Walker, The Battered Woman (New York: Harper and Row, Publishers), 1979.

HANDOUT #4

STRATEGIES FOR WORKING WITH ASSAULTED WOMEN THEIR FAMILIES, AND THE SYSTEMS AROUND THEM

Developed by Frances Woods and Miriam Habib.
For more information, Contact Washington County EOA
P.O. Box 1168, Fayetteville, Arkansas 72701
(501) 521-1394

I. INTERVENTION WITH WOMEN

In working with victims of wife assault the following are important:

1. Affirmation of the woman is of primary importance. Her strengths, the efforts she has and will take to end her being assaulted are very important.
2. A group approach - working with more than one woman at a time is useful for several reasons: it cuts down on the isolation that most women who have been assaulted feel, it provides concrete information that is accurate and sensitive to the women's needs - other women who have experienced the problem are the best experts on it.
3. Recognize that women don't identify themselves as abused because to do so would make them susceptible to society's blaming. i.e., there is something wrong with me, if I put up with it, it's my fault, I must be stupid, etc.
4. Sensitive listening is of utmost importance - we are just learning what this crime is all about, the usual experience of battered women is that no one listens to them or takes them seriously.
5. Stress the fact that the woman is not all alone; stress the fact that you can help the woman.
6. Where possible, give concrete information and aid, for instance have a lawyer available to give legal advice or better, representation. Be available for going to court with the woman, taking her to welfare, etc.
7. Help the woman develop alternatives, where she can go to spend the night, what job training is available.
8. Recognize and deal with the extreme mental and physical exhaustion.
9. Recognize and deal with guilt and shame.
10. Recognize and deal with the fear of being murdered or seriously hurt.

11. Some women will want to try marriage counseling again or for the first time. Some women will recognize that their mates need help. In our experiences, these approaches are successful only if both partners are sincerely interested. This means the male is willing to deal with the issue of his violence and is willing to work in his own problems, with some motive beside keeping the wife in the marriage.

12. Women tend to rationalize and feel sorry for the man since he is "mentally ill", drinks, etc. Help her to take care of herself first.

13. Recent evidence about assaulted women point up that most women can end the abuse only by leaving the marriage. Discuss this in a straight-forward manner which recognizes that it may take the woman some time to reach a decision. Let her know that you support her no matter where she is in her decision making process.

14. Recognize and point out to the woman the usual pattern of going in and out of the relationship until a final decision is made. This includes the woman's decision to try marriage counseling for the first time or again.

15. Recognize and deal with all the societal pressures and role expectation on the woman for keeping her family together at all cost, i.e., "it's my duty to stay with him, the kids need a father", etc. Particularly important are the financial reasons for which a woman stays with ther husband.

16. Help woman work out the particular responses which are most helpful to her, i.e., should she fight back, go to court, etc. Remember this is individualized.

17. Work on developing all independence skills - education, jobs, assertiveness, love of self, self worth.

18. A social-political perspective to this assault on this assault on the woman will help her combat her tendency to accept society's myth that she is to blame for being beaten.

HANDOUT #5

MEN'S INTAKE*

Information on the Violence

22. With whom have you been violent?

Spouse	____ Yes 1	____ NO 2
Ex-spouse	____ Yes 1	____ NO 2
Partner	____ Yes 1	____ NO 2
Ex-partner	____ Yes 1	____ NO 2
*Children	____ Yes 1	____ NO 2
Parents	____ Yes 1	____ NO 2
In-laws	____ Yes 1	____ NO 2
Other family members	____ Yes 1	____ NO 2
Friends	____ Yes 1	____ NO 2
Other ________________ (specify)	____ Yes 1	____ NO 2

INTAKE WORKER:
(IF THERE HAS BEEN VIOLENCE WITH CHILDREN, ARE THEY IN IMMEDIATE DANGER?) ____ Yes ____ NO

23. When was the last violent incident with your partner?

Less than a week ago	1
Between a week and a month ago	2
More than a month, less than three months ago	3
Between three months and six months ago	4
More than six months, less than a year ago	5
A year or more ago	6

23.a. When was the last time you were violent with your child?

*This is part of a Men's Intake form developed by the Domestic Abuse Project, 2445 Park Ave. South, Minneapolis, MN 55404.

24. Now I am going to read a list of things you may or may not have done when you and your spouse/partner had a dispute or at any other time. These are ways of being violent that people in our program report. Please tell me how often you did each one. (These questions refer to the client's present relationship).

1	2	3	4
Never	Once or Twice	Sometines	A lot

A. Not physically violent
1. Discussed issue calmly ____
2. Sulked, refused to tal, withdrew affection or sex to punish ____
3. Stomped out in order to punish ____
4. Screamed, insulted or swore at the other ____
5. Verbally pressured the other to have sex. ____
6. Threatened to leave the marriage or relationship ____
7. Threatened punishment other than physical. (e.g., withholding money, taking away children having an affair) ____

B. Indirect Threats of Violence
1. Restricted physical movement or social contact ____
2. Intentionally interrupted the other's sleeping, or other's eating ____

C. Direct Threats of Violence
1. Threatened to hit or throw something at the other. ____
2. Threw, hit, or kicked something ____
3. Drove recklessly to frighten the other ____
4. Directed anger at or threatened the children ____
5. Directed anger at or threatened the pets. ____

D. Direct Violence
1. Threw something at the other. ____
2. Pushed, carried, restrained, grabbed, shoved, wrestled the other ____
3. Slapped or spanked the other ____
4. Bit or scratched the other ____
5. Throw the other bodily ____

E. Severe violence
1. Choked or strangled the other ____
2. Physically forced sex on the other ____
3. Punched or kicked the other ____
4. Burned the other ____
5. Kicked or punched the other in the stomach when pregnant. ____

6. Beat the other unconscious
7. Threatened with knife, gun or other weapon ____
8. Used any weapon against the other ____
____

F. Other

(Allow reactions about how he is feeling right now.)
Remarks:

25. Please describe the worst incident:

26. What do you usually do after the violence?

27. Has your spouse/partner ever needed medical treatment because of the violence?

_____Yes ____No

28. Has your spouse/partner ever been violent to you? ____Yes ___No

If yes, was your spouse/partner's violence preceded by your violence or threat of violence?

____Yes ___No

29. How often in the last few days have you felt angry?

How do you usually deal with anger toward others (i.e. people besides partner/spouse and children)?

30. How do you usually deal with anger toward yourself?

31. Have you ever attempted to hurt yourself? ____Yes ____No

If yes, please explain.

HANDOUT #6

EXPLANATION OF CHAPTER III - RESTRAINING ORDERS

Chapter III Domestic Abuse Laws
Temporary Restraining Order

STATE OF WISCONSIN
1979 Assembly Bill 169

813.025 (2) (a) A judge may issue a temporary restraining order requiring a person to avoid premises occupied by someone with whom the person is living or has lived in a spousal relationship, as defined in s.46.95 (1) (c), or not to contact that person or both. Such an order may only be issued if the judge has reasonable grounds to believe that a violation of s. 940.19 has occurred or, based on the prior conduct of the parties, may occur. The order may only be issued to the person whom the judge believes has violated or may violate s. 940.19. A petition for the order may be filed by the alleged or potential victim of the violation of s. 940.19. Violation of an order issued under this subsection is punishable under s. 940.33.

(b) Notice need not be given to the defendants prior to the issuance of a temporary restraining order under this subsection. The court may grant the temporary restraining order at any time before the hearing and determination of the application for an interlocutory injunction. The temporary restraining order shall be effective only for 5 days unless extended after notice and hearing thereon, or upon written consent of the parties or their attorneys. The temporary restraining order shall not remain in force beyond the time of the determination of the application for an interlocutory injunction. The order or injunction under this subsection may be issued only by a judge and not by a court commissioner. An injunction under this subsection shall not be effective for more than 2 years.

SECTION 11. 940.19 (1m) of the statutes is created to read:

940.19 (1m) Whoever causes great bodily harm to another by an act done with intent to cause bodily harm to that person or another without the consent of the person so harmed is guilty of a Class E felony.

SECTION 12. 940.33 of the statutes is created to read:

940.33 Violation of certain restraining orders or injunctions. Whoever knowingly violate an order or injunction issued under s. 813.025 (2) is guilty of a Class C misdemeanor.

"Spousal Relationship" - means either a marital relationship or two persons of the opposite sex who share one place of abode with minor children and live together in a relationship which is similar to a marital relationship, except that the two persons are not married to each other.

This restraining order does not cover single woman without children, who is living or has lived with the assailant.

This order is separate from the civil divorce restraining order.

Notice need not be given to the defendant prior to the issuance of a temporary restraining order. But, a person cannot be guilty of violating this order unless he is knowingly doing so. The 5 day temporary order may be issued without the person being served. The temporary order shall be effective for only 5 days unless extended after notice and hearing, or upon written consent of the parties or their attorneys. At the hearing, the order may be made interlocutory for up to two years.

Chapter III, Laws of 1979, states that a judge (not a family court commissioner), may issue a temporary restraining order requiring a person to avoid the premises occupied by someone with whom the person is living or has lived in a spousal relationship, or not contact the person or both.

Violation of a Chapter III restraining order - Whoever knowingly violates an order or injunction issued under s 813.025 is guilty of a class C misdemeanor, which is punishable by a fine not to exceed $500.00, inprisonment not to exceed 30 days or both.

How to get a Chapter III Restraining order - It is not necessary for a woman to retain an attorney to request from the court a Chapter III restraining order, but it is advisable.

An attorney must provide to the judge good cause to believe there is substantial danger to the woman and her dhildren. Threats of violence probably will not be enough. (See Section 11. 940.19).

The forms for the temporary restraining order are available at the Family Court Commissioners Office and Dane County Sheriff's Department.

Dane County Central File System - has been set up to alleviate the following problems that emerged with the new legislation:

1. Law enforcement officers were hesitant in enforcing this order (criminal offense attached) unless the order could be verified.

2. The police must know if the man has either been served, present at a hearing or informed in any other manner. (If the person was not notified, the officer's only recall is to inform the man on the first call, and thereafter if the police only recall is to inform the man on the first call, and thereafter if the police are called an arrest can be made immediately).

3. Even if a woman has a copy of the order with her it may not be signed, has been amended since the date of issuance or dismissed. The officer would hesitate in arresting the assailant.

Please keep in mind this is a new system. Changes in forms and procedures may occur as needed. The central file should solve these problems.

HANDOUT #7

INTERVIEW WITH THE FAMILY

Explanation: This is an interview designed to look at how you function as a family system.

1. Who are each of you?
2. How do you fit into your family?
3. What is your family like for you?
4. Tell a story about your family.
5. How does your family or origin - your mother, father, sisters, brothers fit into your family structure?
6. What rules does your family have?
    a. About household chores and duties.
    b. About child rearing and child care.
    c. About sharing and caring.
    d. About hitting and discipline.
    e. About eating and sleeping.
    f. About fighting.
7. How do you think rules are made in your family?
8. How are rules enforced in your family?
9. If you wanted to change a rule, what would you do?
10. At home, what do you do when you want to be alone?
11. What do other people in your family do when they want to be alone?
12. Waht happens among family members if/when you have friends over to your house?
13. What happens among family members when other people in your family have friends or relatives over?
14. Describe dinner time with your family.
15. How does money come into your family?
    a. Who is in charge of the money?
    b. Who decides what to spend the money on?
    c. Do people in your family have separated (their own) money?
16. How does your family communicate?
17. Who talks to whom in your family?
    a. To whom do you talk?
    b. To whom do you listen?
    c. To whom do you not talk?
    d. To whom do you not listen?
    e. With whom in your family would you share a secret?
    f. With whom in your family would you not share a secret?

18. If a family member is not listened to, what else does/can he/she do to be heard?

19. What happens to make you not talk to each other?

20. What happens to make you start talking to each other again?

21. What subjects are taboo in your family?

22. How does your family deal with the subject of sex?
    a. Is it discussed?
    b. By whom?
    c. Under what circumstances?

23. How does your family fight?
    a. Who starts the fights?
    b. How do you know a fight is coming?
    c. What do family members do during the fight?
    d. What makes the fights violent?
    e. How do the fights end?
    f. What is it like when you are not fighting?
    g. Does the family talk about the fights?

24. How did you and your partner get together?

25. What role do the child(ren) play in you and your partner's relationship?
    a. How do you feel about having children?
    b. How do you think your partner feels about having children?
    c. Do you and your partner talk about how you raise the children?
    d. What do you say to each other?

26. Who usually takes care of the children?
    a. What does taking care of the children entail?
    b. How much time each day do you spend with the children?
    c. How much time each day goes your partner spend with the children?
    d. Do you have separate social time away from the kids?
    e. Does your partner have social time away from the kids?
    f. Do you and your partner have social time away from each other?

27. Which child is easiest for you to deal with?
    Why?

28. Which child is hardest for you to deal with?
    Why?

29. Which child, do you think, is easiest for your partner to deal with?
    Why?

30. Which child, do you think, is hardest for your partner to deal with?
    Why?

HANDOUT #8

CHILD'S INTERACTION WITH SELF

1. Draw a picture of yourself showing a self that you like.

2. Draw a picture of yourself showing a self that you don't like.

3. Draw a life line of things that happened in your life from your first memories to what you think the future might be. Make peaks and valleys in the line to show how you felt about each happening.

5/8/80

HANDOUT #9

DANE COUNTY ADVOCATES FOR BATTERED WOMEN

Child's Intake

(Part I)

This intake form should be done with all children in Shelter ages 5 and up. This should be done with the child and preferably child and staff alone, not with Mom, but family needs to make that decision. Children under 5 should be present when intake is done, but you can ask questions to both Mom and Child.

Name ______________________________ Date ________________

What name do you like to be called? ___________________________

Home Address __________________ Date entered shelter ___________

Age _________ Date of Birth ______________ Phone _____________

1. Why do you think you are at the Shelter? (Take time with this question, explain and possibly set up a specific time to facilitate family discussion around this issue).

2. If you could change something about your family, what would you like to change?

3. What happens when you do something wrong at home?

4. Do your parents hit you?

5. Do you ever hit your parents?

* Explain No Hitting Policy
* Explore reinforcers - What do you like? How could your Mom get you to listen without hitting you?
* Let the child know that this is a safe place for them, but they have responsibilities here at the Shelter. Children are expected not to hit other children, children are expected to help clean up the house, and children are expected to help care for children younger than themselves.

6. Do you want to see your Dad? (or the abuser)

7. If yes, what would you like to do with him?

*Explain that they may not be able to see him for a while but acknowledge their desire:
Remember: some children may not want to see the abuser but due to parental agreements children may have to see the abuser.

8. Have you ever been really sick or hurt?

9. What happened?

10. Are you allergic to anything?

11. If yes, what?

12. What foods do you like best to eat?

13. What are your favorite things about school?

14. Have you ever had problems in school?

15. What are some of the fun things you do at home?

16. Does your Mom or Dad play with you?

17. What do you do when you spend time with your Mom?

18. Do you have any problems or questions that you would like to talk about?

Time of Intake____________________ Staff ____________________________

How many days had family been in Shelter when this intake was done? ____

Any other comments:

HANDOUT #10*

FEELINGS OF A FATHER (ABUSER) AFTER INCEST IS REPORTED

Most families where incest has happened have a fairly rigid structure. That is, each person's role is well defined, social contacts are superficial when they exist at all, and within the family itself there is a complicated network of alliances, collusion, and competition.

The following outline is a generalization which cannot apply to every situation, but depicts what is often seen immediately after incest is reported. Some feelings are of course more obvious than others.

FEAR	These feelings are interwoven strands of the same cable, running concurrently. Fear is rarely expressed openly. It may come out in concern for his job, or he may develop a series of physical symptoms, but generally in our society it is not "manly" to be afraid. Yet, fear is always there because intervention of the legal system takes away his right to make personal choices and he doesn't know what's going to happen to him.
CONFUSED:	The emotional impact of being found out can put the father into a state of confusion. His thinking can be temporarily fragmented as he tries to defend his own actions, search desperately for a way out, fears the loss of his family, or jail, etc.
DESPAIR: SHAME:	Some men experience a deep sense of humiliation and shame after their behavior becomes known outside the family. Some feel so low they consider suicide, a few will make serious suicidal attempts unless they have some form of personal support.
GUILT: RELIEF:	Some fathers feel guilt about their incestuous behavior before it is made known, and almost welcome intervention by the authorities, expressing a strong sense of relief. These are the few who may report themselves, thus getting some outside control to stop their incestuous behavior. Others don't seem to feel any guilt until they are more aware of their daughter's distress. Some feel no guilt at all.
HOSTILE & RESENTFUL:	As a cover-up to the fear mentioned above, some fathers feel very angry about the intervention in their family. They may feel the system is victimizing them by destroying the family balance, jeopardizing their jobs and social standing, and alienating family members. The protest they can straighten out everything themselves if left alone.
REMORSE:	A few fathers make some comments of remorse, but our impression is their own well-being is of paramount importance. It is not at all clear initially that they have any concern for the welfare of their families, such as how their wife or children will manage socially or economically. His own

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*These handouts were developed by Parental Stress, 1506 Madison St., Madison, WI.

discomfort obviates this.

Occasionally, a father will feel so full of guilt and remorse, he will become compliant and servile, anxious to please.

CHARACTERISTICS OF A FATHER (ABUSER) AFTER INCEST IS REPORTED

Again, the following observations are generalizations. They will not apply to every situation but represent at least in part the most frequently seen behavior and thought processes of father-abusers shortly after being confronted.

DENIAL: Most men deny their involvement with incest as a reflex to protect themselves from self-incrimination. Even after admitting, they will deny that it has any traumatic effect on the daughter or the family. Denial serves to blunt the pain and soreness of feeling fear, shame, guilt, etc. They also hope to protect their jobs and social standing.

RATIONALIZATION Nearly all abusers try to explain away their behavior. This commonly takes the form of: "I wanted to teach her how to handle herself with men", or "She really "came on' to me by sitting on my lap with only her nightie on", or "If my wife paid more attention to me, I wouldn't need sex from someone else", or "At least I kept it in the family so I wouldn't bring hom V.D.", or "My Dad (or Mom) did it to me...", as though they can take only the most minimal responsibility for their actions, if any responsibility at all.

BELIEVE THEY ARE MISUNDERSTOOD: Sexually abusive fathers feel love and affection for their daughters, and are (despite the social taboo) bewildered that outsiders become so outraged and accusatory. They did not want to hurt their daughters ("She seemed to like it as much as I did"). To diminish a sense of being attacked, they will often agree verbally that they were wrong, don't know why they did it, and plead for help.

MANIPULATION At this initial stage, the father may appear compliant to the requirements of the law and the system. At the same time, he may be pressuring his wife and children to make them feel guilty for pressing formal charges, to make them feel helpless or economically impotent if he is taken out of the home, and he may exert complete control of what happens next.

For example, because of his religious beliefs, he will go only to a religious therapist. Once in therapy, he will likely deal with all kinds of problems EXCEPT the incest. One family moved [illegible] had no phone, so all contacts with the family were filtered through the father who was incarcerated in a mental institution.

> Many fathers become adroitly evasive. They make dental appointments which conflict with therapy. A relative dies and they have to go to the funeral. A child ran away, or needs emergency medical care. Some miss appointments due to some other stress and "I forgot". Others are even more astute and find a therapist who will have the wife and children take part in therapy, diluting the father's responsability for his behavior. Some simply lie about what is going on.

BRIEF STATEMENT OF THERAPEUTIC PHILOSOPHY

Nearly all of us have an abhorrence for the act of incest and the person responsible for it. Some understanding of the abuser can mitigate those feelings so we can work therapeutically with the abuser. It is also important that the therapist have clear-cut standadards and values of her/his own.

Most abusers have had a severely deprived childhood and many were themselves sexually abused. They may have been enconomically well provided for, but emotionally neglected or abused. Anu sexual act with their child is more likely an attempt to get for themselves some very basic and elementary tender loving care, rather than sex per se. Some professionals believe the father is in an altered state when the incest occurs.

Any sexual act with one's children is grossly inappropriate regardless of how "understandable". The primary therapeutic goal in working with fathers is to stop the incest, and to resocialize him: they must learn to get their basic needs met in a more socially acceptable way.

When alcohol or other chemical dependency is currently a problem, it must be considered the primary problem. Chemical dependency superimposes its pathology on everything else and will effectively interfere with all other therapeutic endeavors.

Neither the sex of the therapist nor the modality used (e.g., Gestalt, T.A., Humanistic, etc.) has any negative effect on the effectiveness of treatment.

Historically, "man's home is his castle" and what he does there has been considered unimpeachable. Even in so-called "matriarchal" homes, our society has delineated the father's role as breadwinner and "head of household". Most men have perpetuated the roles they were taught. As the Women's Movement unfolds, we see increasing unrest and disequilibrium within family units as individuals redefine their roles. The political mores of the past (for example, no one challenges the man's "right" to beat his wife or molest his child) are slowly being confronted.

Regardless of the political aspect, the father must find other ways to gratify his emotional (and sexual) needs. It is our belief this cannot be accomplished only in one-to-one therapy, just as a shoe cannot be laced if it has only one eyelet.

Self-help therapy groups provide invaluable peer support and reality testing as well as new social outlets. Other family members also need personal therapy and couples counseling (mother-daughter, father-mother, father-daughter, siblings), and lastly, family therapy is most effective only after individuals have resolved to some extent their own acute feelings.

Throughout all this, the various therapists and counselors must have a way of staying in touch with each other in order to keep the overall therapeutic endeavor cohesive and non-fragmented.

HANDOUT #11

FEELINGS OF A MOTHER AFTER INCEST IS REPORTED

Most families where incest has happened have a fairly rigid structure. That is, each person's role is well defined, social contacts are superficial when they exist at all, and within the family itself there is a complicated network of alliances, collusion, and competition.

The following outline is a generalization which cannot apply to every situation, but depicts what is often seen immediately after incest is reported. Some feelings are of course more obvious than others.

SHOCK: HORROR DISBELIEF:	The mother's first reaction is one of horror, shock, and disbelief that comes from feeling disgraced and wanting intensively for it not to be true. Part of the shock is to feel numb, confused, guilty, betrayed. She suddenly feels cut off from both her husband and her daughter. Her well-established emotional ties have been fractured and there follows a period during which she flounders, wondering what to do.
VICTIMIZED: ANGRY: ENRAGED:	She is immediately put in the middle, having to choose between her husband and child, and she stands to lose a lot no matter how she chooses. Most mothers feel victimized by a situation they had no direct part in, yet must shoulder major responsibility for resolving. This situations generates a lot of frustration leading to anger and sometimes rage, which can be expressed or suppressed or repressed. It is always there. All mothers experience episodes of intense anger. Besides the husband and the daughter, the target of that anger can be the human services system which is intervening. In that process, the mother may feel misunderstood or accused, being told what to do without regard for her feelings and anxieties. She sees herself as an innocent bystander, yet she must take on the onus of getting help for her daughter and her husband, and indeed participate in the therapy process whether she wants to or not. For some mothers/wives, this experience culminates in a sense of Utter Victimization. She may have had tendencies toward feeling a victim (martyr) in her ordinary day to day life as the fixer, go-together, care-taker who rarely had time or energy to call her own. Now she must make additional sacrifices and take responsibility for facilitating some of the treatment process for a situation she had nothing to do with.
AMBIVALENCE:	Nearly all mothers experience some ambivalence, not toward the act of incest (which they abhor), but toward their partner and their child. In the past, professionals have

attributed the mother with ambivalence in nearly all cases ("unconsciousl- promoting" sexual abuse, setting up conditions so the inces could happen). While this may be true in a few instances, it is our opinion that the mother has not learned until now the need to protect her child from her partner. It is untenable to call the mother's plight "ambivalence". Rather, in the shock and confusion of finding out about the incest, it takes time for the mother to absorb the fact she must in some way physically intervene to stop the abuse. As others have said, how can a mother know *before* incest happens that her child needs to be chaperoned with her own father?

The ambivalence toward her mate rests on her abhorrence for what he has done, and her continuing caring for him. She feels this is irrational. Her ambivalence for her daughter is related to the repugnance and jealousy mentioned below, plus her reaction to the fact that her daughter may be blaming the mother for not protecting her.

A few mothers have no ambivalence at all.

GUILTY: INADEQUATE: FEAR:	She fears public disclosure and embarrassment, and she may feel guilty and inadequate as wife and mother, wondering if this is all her fault. The family is usually well thought of by neighbors and upstanding in the community. The mother fears destruction of her family. Her partner or spouse may go to jail. Her child may go to a foster home. She fears loss of economic support and has tremendous anxiety about supporting the family.
REPUGNANCE:	The mother may have been sexually abused as a child herself, and discovering it in her own family may dredge up old unresolved feelings, compounding her present problems.
JEALOUSY:	Some mothers may feel jealous of their daughter, and may wonder if the daughter engaged in seductive behavior.
DENIAL:	Nearly all mothers have some degree of denial upon first learning about the incest. It is a disservice to think of this as resistance. Denial is a survival tool: it helps to absorb the intense fear and anger. It buys valuable time until the person can feel strong enough to face the problem for herself. It also helps dilute the sense of debasement.
MANIPULATION	The father's manipulation is geared to his own denial and self-protection. The mother's manipulative maneuvers seem somewhat similar, but there is for her an added overlay of fear, anxiety, and confusion regarding her own destiny. Many mothers have learned to survive by using manipulation as a life style to get her minimum needs met indirectly. It is important NOT to assume she is evasive or resistive, but to recognize her need to be in control and give support where possible.

BRIEF STATEMENT OF THERAPEUTIC PHILOSOPHY

The primary goal of treatment is to stop the incest, and to reconstitute the family where possible. This is immediately undertaken by providing each member of the incest triangle with his and her own support system, most often a person from Oasis-Parents United, e.g., another mother who has experienced a similar thing. There is nothing more supportive than hearing from someone who "has been there". It is here where the person begins to feel faint hope. This other parent may also function as an ally or advocate in the legal system.

Most often mothers are so dedicated to nurturing the rest of the family, they are unable to recognize their own feelings. If they do get a glimmer of, for example, anger, it causes a tremendous anxiety that they might commit mayhem or have a nervous breakdown, or some similar disaster. They need encouragement to express their feelings, to get to know themselves as individuals, and to start making some claims for satisfaction and gratification of their own. While this can be done in private therapy, the same message from peers seems to carry more weight. It is rewarding to see a mother start to make her own decisions, her own choices! It is then she can become more substantially nurturing because she has begun to allow herself to be nurtured.

The incest experience always requires dealing with the mother-daughter relationship at some point. This cannot be done until each of them has regained some personal equilibrium. Often, each of them can "practice" through role play with an unrelated person before actually coming to grips with their feelings with each other.

When alcohol or other chemical dependency is a current problem, it must be considered the primary problem, because it super-imposes its pathology on everything else and will effectively interfere with all other therapeutic endeavors.

Neither the sex of the therapist nor the modality used (e.g., Gestal, T.A., Humanistic, etc.) has any negative effect on therapy.

As the Women's Movement unfolds, we see increasing unrest and disequilibrium within family units as individuals redefine their roles. The political mores of the past (for example, no one challenges the man's "right" to beat his wife or molest his child) are slowly being confronted.

Regardless of the political aspect, family members MUST find better ways to gratify their emotional (and sexual) needs. It is our belief this cannot be accomplished only in one-to-one therapy, just as a shoe cannot be laced if it has only one eyelet.

Self-help therapy groups provide invaluable peer support and reality testing as well as new social outlets. Other family members also need personal therapy and couples counseling (mother-daughter, father-mother, father-daughter, siblings), and lastly, family therapy which is most effective only after individuals have resolved to some extent their own acute feelings.

Throughout all this, the various therapists and counselors must have a way of staying in touch with each other in order to keep the overall therapeutic endeavor cohesive and non-fragmented.

HANDOUT #12

FEELINGS A VICTIM MAY HAVE WHEN THE INCEST HAS BEEN REPORTED: (*)

CONFUSION: Her feelings don't fit together well.

PANIC: **FEAR:** She has second thoughts; perhaps she shouldn't have told. Are people blaming her? Do they feel she's dirty, bad, seductive? How will her family react? What will happen to her family? Will her Mom still love her? What will happen to the people in her family? She has betrayed them.

ANGER: Everything may seem to be out of her control now. She feels as if she's on a rollercoaster ride that gets scarier that she'd expected; she may feel she wants to get off in the middle. She may fear she has made a bad decision to tell; and she may try to back out. She may even change her story and deny that she was ever sexually abused. She may become very angry at the person who reported. This person who reported may be a trusted friend; teacher, school counselor, or therapist - and it comes as a real shock when she suddenly turns her anger towards this person. However, she is feeling backed into a corner.

REVENGE: **RELIEF:** She is finally getting back at the person who mis-used her. She is somebody important. She is being listened to and trusted. Now somebody will take care of her. It is a new feeling when the burden drops from her shoulders onto somebody else's. She may have been carrying this secret for a very long time.

DOUBTS: **GUILT:** **REGRET:** She begins to doubt her memory about the incest. She may begin to feel that it wasn't really all that bad - other people have had worse things happen to the. She wasn't hurt - it's all over now. And really, the person who sexually abused her was often very nice to her. They were special friends. Maybe it was partly her fault. She had after all, liked it when he hugged her and told her she was special. She may have wanted that. She may have enjoyed some parts of the sexual experience. She wonders now why she didn't tell somebody sooner - maybe then things wouldn't have gone as far as they did. It feels good at this point to hear that children have a right to have affection from their fathers; it was OK for her to want to be special to her father; and it was her father who broke the rules by becoming sexual with her.

ASHAMED: It seems that everybody knows about he and her family now. She feels ashamed about the experiences she has had. She is convinced she is different from everyone and is afraid people will be watching her and thinking bad things about her.

FEAR: The person who sexually abused her may have made some threats about what he might do if she told. They may be threats to do her bodily harm; or they may be threats about what he might do to himself or her family. She fears the threats may be followed through. She fears facing the abuser during any of the court proceedings.

RESPONSIBLE: She feels responsible for everyone's misery! She worries about everyone in her family. She wonders if this might drive her mother over the edge; will her Dad go to jail? What about her brothers and/or sisters? How will they suffer? Will people be looking at them and wondering about them too?

ABANDONED

BETRAYED

ALONE

SUICIDAL

Sometimes a victim's family rejects her when the incest is reported. Her father may call her a liar, Mom says she is promiscuous and seductive; and her brothers and/or sisters may deny anything ever happened to them, even though it may have. She may feel she has completely lost her family which is very important to her. She may consider suicide at this point; or she may deny that losing her family matters to her and pursue her complaint with renewed vigor. Should she be rejected by her family, it is wise to note which route she is pursuing.

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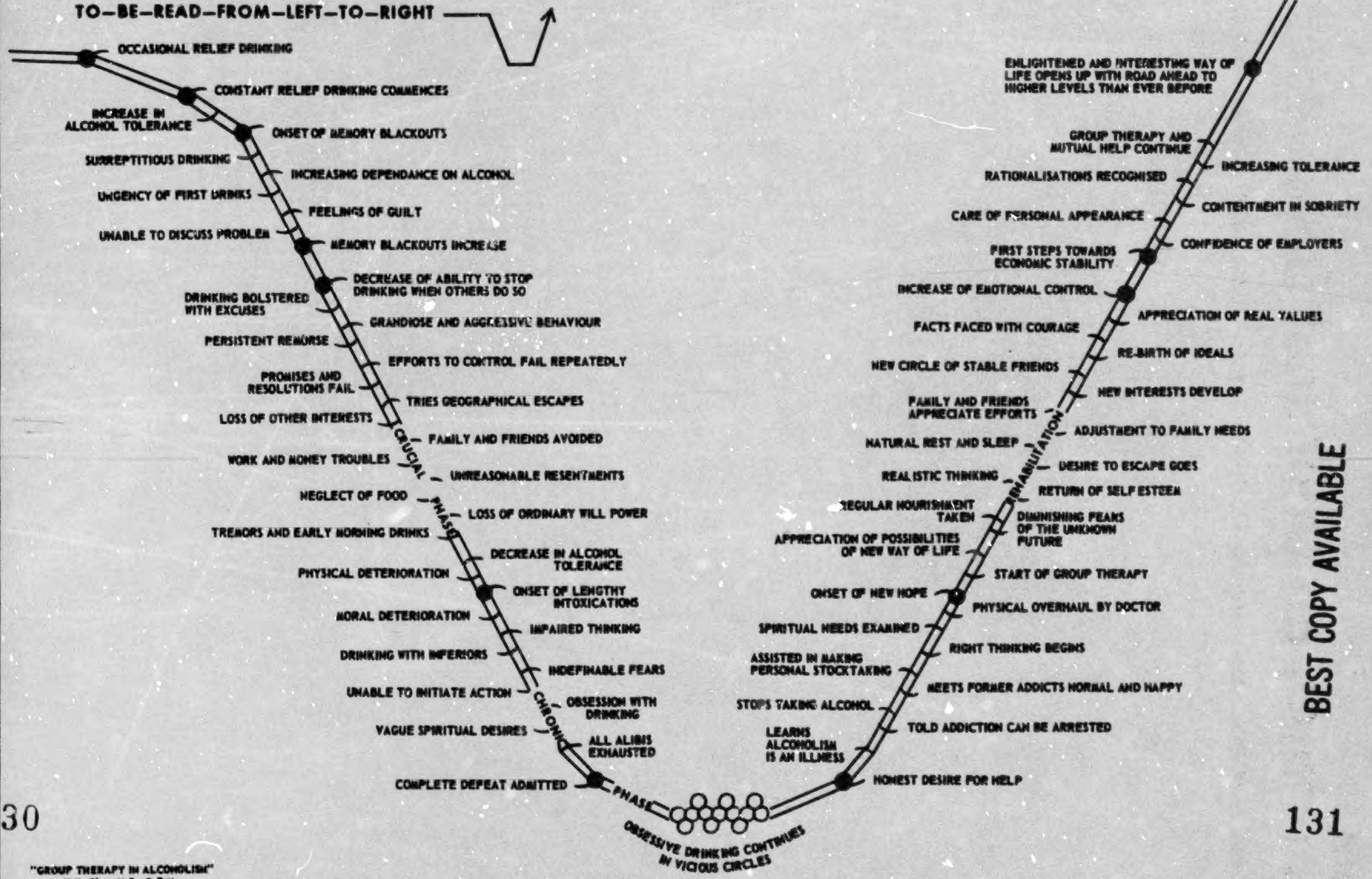
* Our experience is mostly with father-daughter incest. Hence, when we talk about a victim, we will talk about "she". We know this person might sometimes be a "he".

Appendix E

Handouts on Chemical Dependency

HANDOUT A


TO-BE-READ-FROM-LEFT-TO-RIGHT
OCCASIONAL RELIEF DRINKING
CONSTANT RELIEF DRINKING COMMENCES
INCREASE IN ALCOHOL TOLERANCE
ONSET OF MEMORY BLACKOUTS
SURREPTITIOUS DRINKING
INCREASING DEPENDANCE ON ALCOHOL
URGENCY OF FIRST DRINKS
FEELINGS OF GUILT
UNABLE TO DISCUSS PROBLEM
MEMORY BLACKOUTS INCREASE
DECREASE OF ABILITY TO STOP DRINKING WHEN OTHERS DO SO
DRINKING BOLSTERED WITH EXCUSES
GRANDIOSE AND AGGRESSIVE BEHAVIOUR
PERSISTENT REMORSE
EFFORTS TO CONTROL FAIL REPEATEDLY
PROMISES AND RESOLUTIONS FAIL
TRIES GEOGRAPHICAL ESCAPES
LOSS OF OTHER INTERESTS
CRUCIAL PHASE
FAMILY AND FRIENDS AVOIDED
WORK AND MONEY TROUBLES
UNREASONABLE RESENTMENTS
NEGLECT OF FOOD
LOSS OF ORDINARY WILL POWER
TREMORS AND EARLY MORNING DRINKS
DECREASE IN ALCOHOL TOLERANCE
PHYSICAL DETERIORATION
ONSET OF LENGTHY INTOXICATIONS
MORAL DETERIORATION
IMPAIRED THINKING
DRINKING WITH INFERIORS
INDEFINABLE FEARS
UNABLE TO INITIATE ACTION
OBSESSION WITH DRINKING
VAGUE SPIRITUAL DESIRES
CHRONIC PHASE
ALL ALIBIS EXHAUSTED
COMPLETE DEFEAT ADMITTED
OBSESSIVE DRINKING CONTINUES IN VICIOUS CIRCLES
HONEST DESIRE FOR HELP
LEARNS ALCOHOLISM IS AN ILLNESS
TOLD ADDICTION CAN BE ARRESTED
STOPS TAKING ALCOHOL
MEETS FORMER ADDICTS NORMAL AND HAPPY
ASSISTED IN MAKING PERSONAL STOCKTAKING
RIGHT THINKING BEGINS
SPIRITUAL NEEDS EXAMINED
PHYSICAL OVERHAUL BY DOCTOR
ONSET OF NEW HOPE
START OF GROUP THERAPY
APPRECIATION OF POSSIBILITIES OF NEW WAY OF LIFE
DIMINISHING FEARS OF THE UNKNOWN FUTURE
REGULAR NOURISHMENT TAKEN
RETURN OF SELF ESTEEM
REALISTIC THINKING
DESIRE TO ESCAPE GOES
REHABILITATION
NATURAL REST AND SLEEP
ADJUSTMENT TO FAMILY NEEDS
FAMILY AND FRIENDS APPRECIATE EFFORTS
NEW INTERESTS DEVELOP
NEW CIRCLE OF STABLE FRIENDS
RE-BIRTH OF IDEALS
FACTS FACED WITH COURAGE
APPRECIATION OF REAL VALUES
INCREASE OF EMOTIONAL CONTROL
FIRST STEPS TOWARDS ECONOMIC STABILITY
CONFIDENCE OF EMPLOYERS
CARE OF PERSONAL APPEARANCE
CONTENTMENT IN SOBRIETY
RATIONALISATIONS RECOGNISED
INCREASING TOLERANCE
GROUP THERAPY AND MUTUAL HELP CONTINUE
ENLIGHTENED AND INTERESTING WAY OF LIFE OPENS UP WITH ROAD AHEAD TO HIGHER LEVELS THAN EVER BEFORE

BEST COPY AVAILABLE

"GROUP THERAPY IN ALCOHOLISM"
M.M. Glatt, M.D., D.P.M.
Warlingham Park Hospital

A CHART OF ALCOHOL ADDICTION AND RECOVERY

Reprinted from
THE BRITISH JOURNAL OF ADDICTION
Vol. 54, No. 2

Distributed by
NATIONAL COUNCIL ON ALCOHOLISM, INC.
2 East 103rd Street, New York 29, N.Y.

HANDOUT B

CHEMICAL DEPENDENCY WORKSHEET*

NAME ______________________ DATE __________________

GENERAL ASSESSMENT

______1. Have you ever had problems with your health?
______2. Have you ever had any legal problems?
______3. Have you ever been separated or divorced?
______4. Have you ever seen a psychologist, psychiatrist, or other therapist?
______5. Have you ever been admitted to a psychiatric or mental health unit?
______6. Have you ever been admitted to a hospital for problems related to your use of alcohol and/or medication?
______7. Have you ever received help from CADAR detoxification center?
______8. Are you unemployed or on disability?
______9. Have you ever had problems with your work and/or the people you work with?
_____10. Have you ever had any financial problems?

CHEMICAL DEPENDENCY ASSESSMENT

_____11. Have you ever used medications to help you sleep, relax, or to relieve pain?
_____12. Have you ever used alcohol to help you sleep, relax, or to relieve pain?
_____13. Has there ever been alcohol or other drug related problems in your family?
_____14. Have you ever over-medicated yourself?
_____15. Have you ever drunk alcohol while you were taking medications?
_____16. Have you ever been concerned about your ability to perform sexually?
_____17. Have you ever been arrested for drunk driving?
_____18. Have you ever had difficulty remembering what you did while you were drinking or taking drugs?
_____19. Have you ever drunk alcohol or taken drugs for extended periods of time?
_____20. Have you ever decided to quit or cut down on your drinking/drug taking?
_____21. Have you ever abstained (no drinking) from alcohol for more than one month in the past two years?
_____22. Have you noticed that it takes more alcohol/drugs now to change your mood than it did in the past?
_____23. Have you ever taken alcohol to prevent the results of a hangover?
_____24. Is anyone in your family concerned about your drinking/drug taking?
_____25. Have friends or family ever commented that you drink too much or take too many drugs?
_____26. Have you ever tried to limit your intake of alcohol/drugs?
_____27. Have you ever drunk alcoholic beverages when you were alone?
_____28. Have you noticed that you can no longer predict how alcohol/drugs will affect you?
_____29. Have you ever felt that you become a different person when you drink or take drugs?

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*Developed by PICADA, Inc., 17 N. Webster St., Madison, WI. 53703

_____30. Have you ever experienced severe guilt/remorse because of your drinking/drug taking?

_____31. Has anyone ever pressured you to seek help because of your drinking/drug taking?

_____32. Have you ever drunk alcoholic beverages upon waking?

_____33. Have you ever hidden alcohol or drugs?

_____34. Have you ever had a seizure or convulsion?

_____35. Have you ever experienced increased anxiety, irritability, sweating, nausea/vomiting, or any other complications after drinking/drug taking?

_____36. Have you ever seen things that others said weren't there?

_____37. Have you ever had numbness and/or tingling in your hands or feet?

_____38. Do you experience memory lapses frequently?

MENTAL ASSESSMENT

_____39. Have you ever thought you may be going crazy?

_____40. Have you ever been concerned about your mood (the way you feel)?

_____41. Do you currently dislike yourself?

_____42. Do other people frequently interfere with what you'd like to do?

_____43. Have you been depressed for a long period(s) of time?

_____44. Have you ever considered taking your own life?

_____45. Have you ever attempted to take your own life?

_____46. Have you ever attempted to harm yourself or another person?

_____47. Have you ever felt that voices were telling you what to do?

_____48. Have you ever felt as if you were leaving your body?

_____49. Have you ever felt that people were trying to hurt or control you?

CHEMICAL DEPENDENCY #2 ASSESSMENT (AFFECTED FAMILY MEMBER)

_____50. Have you ever covered up (conceal, protect or deny) for the drug/alcohol abuser?

_____51. Have you ever felt guilty believing that somehow you caused the drug/alcohol abuser's condition to worsen?

_____52. Has your attitude toward the drug/alcohol abuser ever changed in extremes - alterating between love and hate?

_____53. Have you ever felt that everything in your life would be OK if only the drug/alcohol abuser would stop or control the drinking/drug use?

_____54. Have you ever felt excessive guilt, self-pity, worry, and/or resentment in relation to the behavior of the drug/alcohol abuser?

HANDOUT C

ADULT CHEMICAL DEPENDENCY #2 WORKSHEET

_____ 1. Have you ever attempted to change yourself in order to keep the abuser from drinking or using other drugs?
_____ 2. Have you ever thought or said if s/he really loved me, s/he would stop drinking or using other drugs?
_____ 3. Have you ever been upset by anticipating the use of alcohol or other drugs by the abuser?
_____ 4. Have you ever gotten angry at the abuser and taken it out on family, friends or other people?
_____ 5. Have you ever tried to arrange everything "just right" so that the abuser won't find an excuse to drink or use drugs?
_____ 6. Have you ever felt you were going crazy because your memory of events was different from the abuser's?
_____ 7. Have you ever felt that something was seriously wrong with the abuser's use of alcohol or other drugs?
_____ 8. Have you ever felt the alcohol or other drugs were more important to the abuser than you are?
_____ 9. Have you ever assumed chores and responsibilities that you would normally expect the drug/alcohol abuser to assume?
_____10. Has your attitude toward the drug/alcohol abuser ever changed in extremes alternating between love and hate?
_____11. Have you ever thought that everything would be all right if the abuser would just stop using alcohol/drugs?
_____12. Have you ever been in a dangerous situation due to the abuser's use of alcohol/drugs? (i.e., driving, boating, smoking, etc.)
_____13. Have you ever been blamed for the alcoholic's/drug abuser's behavior?
_____14. Have you ever avoided discussing the behavior of the alcohol/drug abuser?
_____15. Have you and/or your children ever withdrawn from outside activities/friends in response to the behavior of the alcohol/drug abuser?
_____16. Have you ever withheld sex as a result of the alcohol/drug abuser's behavior?
_____17. Have you ever suffered physical abuse?
_____18. Has anyone ever expressed concern about you and/or your situation?
_____19. Has anyone ever suggested that you seek professional help?
_____20. Have you ever covered up for the drug/alcohol abuser? (concealed, protected or denied)
_____21. Have you ever felt guilt, self-pity, worry, and/or resentment in relation to the behavior of the drug/alcohol abuser?
_____22. Have you ever experienced problems with sex in response to the drug/alcohol abuser's behavior?
_____23. Have you ever lost sleep worrying about the behavior of the drug/alcohol abuser?
_____24. Have you ever made the drug/alcohol abuser promise to cut down or control their drinking or other drug use?
_____25. Have you ever made threats to the drug/alcohol abuser and not followed through on them?

_____26. Have you ever marked, hid, diluted, and/or emptied bottles of liquor or medication?

_____27. Have the children in your family ever taken sides with either parent in response to conflict concerning the drug/alcohol abuser's behavior?

_____28. Have the children in your family ever shown signs of emotional stress such as declining school performance, acting out, or isolating themselves?

_____29. Have you ever experienced physical symptoms in yourself, such as nausea, headaches, gastro-intestinal problems, ulcers, shakiness, sweating palms, or bitten fingernails?

_____30. Have you ever drunk excessively or used medications in response to drug/alcohol abuser's behavior?

HANDOUT D

FAMILY

LEARNING

°Chemical Dependency - not identified as a problem yet
°Family is learning how to cope with a dependency related stress
°As disease process develops, all those close to C.D. know stress is present and family life or relationship is changing.
°Stress may manifest itself in increasing arguments, tension, less communication, marital/family conflicts, emotional distance, abuse.
°Defensive behaviors evolve.
°Habit-forming reaction patterns.

SEEKING

°Family seeking answers to the problem; trying to control the problem.
°Lack of cultural guidelines.
°Flashes of awareness that maybe the chemical abuse is the problem.
°This thought is quickly rationalized away (blackout) and replaced by a false hope that chemical abuse is really not the problem.
°This process is called "Family Denial"
°Over time, the evidence is too clear to ignore.
°The family sincerely believes they can control the chemical use by manipulating the environment:

- More Loving
- More Achieving
- Acting out
- Blaming
- Withdrawing

°The sincere belief that the family members can control the chemical use is called a "Family Delusion" (the reality of chemical dependency is that no amount of manipulation or defensive behaviors can control the dependency or the person).
°Denial and delusion enable the illness process (see handout on enabling)
°Unhealthy coping styles eventually catch up with the family turning the members into angry, resentful, and emotionally-tangled people.
°Denial encouraged by cultural stereotype of chemical dependency and periods of abstinence or "good behavior"
°All problems avoided, "Don't Rock the Boat".

HARMFUL

°Family's defensive strategies become compulsive
1. "Too Good"
2. "Rebellious"
3. "Apathetic"

°The family blames the chemical dependent as if she/he freely chose to become chemically dependent.
°Paradox of delusion: Family feels helpless to control drug abuse yet believes are the cause in the first place.

- °Isolation: reduce visibility, loss of perspective, magnifies importance of each family member's behavior.
- °Family unconsciously builds a higher denial system ("Everything is All Right").
- °Acceptance of painful lifestyle as a normal way of life.
- °Attempts to cover up increase; "Daddy is Ill".

ESCAPE

- °Lifestyle of family becomes undeniably painful.
- °Family begins to look for a way out.
- °Repeated crises; financial, work, social, emotional.
- °Overpowering feelings of guilt, vulnerability, anger, lonliness, resentment, hurt, fear...
- °Emotionally exhausted, trapped, empty, tired of trying, numb.
- °Many problems in decision to terminate marriage/relationship:
    - Emotional conflicts.
    - Practical circumstances (cost/benefit equation)
    - Conflicting advice by relatives, friends, and social agencies.
    - Children.
- °Walking away seems the best way to survive.
- °Separation does not eliminate the painful emotions, the lifestyle habits or the resentments.
- °Help required to facilitate recovery.

Johnson Institute, "Chemical Dependency: A Family Affair."
Maxwell, Ruth, The Booze Battle.
Reddy, B., "Alcoholism: A Family Illness".

HANDOUT E

SYSTEM DYNAMICS OF THE ALCOHOLIC FAMILY*

Role	Motivating	Identifying Symptoms	Payoff		Possible Price
			For Individual	For Family	
Dependent	Shame	Chemical use	Relief of pain	None	Addiction
Enabler	Anger	Powerlessness	Importance; self-righteousness	Responsibility	Illness, "martyrdom"
Hero	Inadequacy; guilt	Overachievement	Attention (positive)	Self-worth	Compulsive Drive
Scapegoat	Hurt	Delinquency	Attention (Negative)	Focus Away from dependent	Self-destruction addiction
Lost child	Loneliness	Solitariness, Shyness	Escape	Relief	Social isolation
Mascot	Fear	Clowning, Hyperactivity	Attention (amused)	Fun	Immaturity; emotional illness

* Taken from: Another Chance: Hope + Health for the Alcoholic Family, by Sharon Wegscheider.

HANDOUT F

CHILDREN'S WORKSHEET

GENERAL ASSESSMENT (Any yes response warrants further assessment)

_____1. Have you ever been sick for more than two days at a time?

_____2. Have you ever stayed overnight in the hospital?

_____3. Have you ever talked with a school counselor, doctor, psychiatrist or counselor?

_____4. Have you ever been in the hospital because of drinking or drugs?

_____5. Have you ever had problems at school?

_____6. Have you ever had problems at home?

_____7. Have you ever had problems with your friends?

_____8. Have the police ever been to your house?

CHEMICAL DEPENDENCY ASSESSMENT (Any yes reponse indicates possible chemical dependency. More than 3 yes responses indicates chemical dependency)

_____9. Do you have trouble getting along with the drinker or drug user?

_____10. Have you ever used medicine to help you sleep or relax?

_____11. Have you ever used alcohol or other drugs to help you sleep or relax?

_____12. Have there ever been drinking or drug problems in your family?

_____13. Have you ever had trouble remembering what you did when you drank or took drugs?

_____14. Have you drunk alcohol or taken any other drug more than once a month?

_____15. Have you ever been worried about your drinking or your taking drugs?

_____16. Is anyone in your family worried about your drinking or your using drugs?

_____17. Have you ever hidden alcohol or drugs?

MENTAL ASSESSMENT (Any yes response warrants further assessment)

_____18. Have you felt confused?

_____19. Do you not like yourself?

_____20. Do you feel sad often?

_____21. Have you ever tried to hurt yourself or others?

_____22. Have you ever felt people were trying to hurt you?

_____23. Have you ever heard voices or seen things that weren't there?

CHEMICAL DEPENDENCY #2 ASSESSMENT - Affected Family Member

(Any yes response warrants further assessment)

_____1. Have you ever told stories to protect the alcohol or drug user?

_____2. Have you ever felt you caused someone to drink or use drugs?

_____3. Have you ever been angry at the alcohol or drug user?

_____4. Have you ever wished he cr she would stop drinking or using drugs?

_____5. Have you ever worried about the alcohol or drug user when you were away from home?

_____6. Have you ever had trouble listening in school?

_____7. Have you ever heard fights at night?

_____8. Have you ever had trouble sleeping?

_____9. Have you ever asked the alcohol or drug user not to drink or use drugs?

_____10. Have you ever been afraid to have friends over because of the alcohol or drug user?

_____11. Have you ever pretended that everything was OK at home when it wasn't?

_____12. Have you ever taken over the work that the alcohol or drug user would do?

_____13. Have you ever had an upset stomach or a headache because you were worried about the alcohol or drug user?

_____14. Have you ever wondered if the alcohol or drug user loved you?

_____15. Has anyone in your family ever hit you or touched you in a way that upset you?

HANDOUT G

WHAT IS DENIAL?

Denial is a psychological mechanism or process by which human beings protect themselves from something threatening to them by blocking knowledge of that thing from their awareness.

The denial that this thing exists in their lives is below the level of awareness. It is done subconsciously. In other words the person doesn't know or is unwilling to admit that it exists.

The problems overshadow or cloud a person's ability to realize or recognize that the thing, set of circumstances, events or phenomenon are actually happening in their lives.

It impairs judgment and results in self-delusion which locks the individual into an increasingly destructive pattern of living.

This process of denial has many faces which may manifest or characterize themselves in any one or more of the following ways:

1. Simple denial - maintaining that something is not so which is indeed a fact and very obvious to important others in the person's life.
2. Minimizing - admitting superficially to the problem but will not admit that it is serious in scope.
3. Blaming (also called projection) - denying responsibility for certain behavior and fixing the blame on someone or something else.
4. Rationalizing - offering alibis, excuses, justifications or other explanations for behavior. The behavior is not denied but an inaccurate explanation of its cause is given.
5. Intellectualizing - avoiding emotional, personal awareness of a problem by dealing with it on a level of generalization, intellectual analyses, or theorizing.
6. Diversion - changing the subject to avoid discussion of the topic that is threatening.
7. Hostility - becoming angry or irritable when reference is made to the problem causing conflict. This is a defense to back the challenger off the problem.

Denial is automatic - it operates below the level of awareness - the affected individual does not really know that he/she is engaging in the acts of denial.

Denial is progressive - the affected individual sets up such an elaborate system of denial mechanisms that they pervade the entire personality and become so enmeshed that they are extremely difficult to penetrate.

Taken from: Dealing with Denial, #6 in the Caring Community Series.
Published by Hazelden Foundation.